

Global Governance *for* Health

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The political origins of health inequity: prospects for change

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Executive summary

Despite large gains in health over the past few decades, the distribution of health risks worldwide remains extremely and unacceptably uneven. Although the health sector has a crucial role in addressing health inequalities, its efforts often come into conflict with powerful global actors in pursuit of other interests such as protection of national security, safeguarding of sovereignty, or economic goals.

This is the starting point of *The Lancet*–University of Oslo Commission on Global Governance for Health. With globalisation, health inequity increasingly results from transnational activities that involve actors with different interests and degrees of power: states, transnational corporations, civil society, and others. The decisions, policies, and actions of such actors are, in turn, founded on global social norms. Their actions are not designed to harm health, but can have negative side-effects that create health inequities. The norms, policies, and practices that arise from global political interaction across all sectors that affect health are what we call global political determinants of health.

The Commission argues that global political determinants that unfavourably affect the health of some groups of people relative to others are unfair, and that at least some harms could be avoided by improving how global governance works. There is an urgent need to understand how public health can be better protected and promoted in the realm of global governance, but this issue is a complex and politically sensitive one. Global governance processes involve the distribution of economic, intellectual, normative, and political resources, and to assess their effect on health requires an analysis of power.

This report examines power disparities and dynamics across a range of policy areas that affect health and that require improved global governance: economic crises and austerity measures, knowledge and intellectual property, foreign investment treaties, food security, transnational corporate activity, irregular migration, and violent conflict. The case analyses show that in the

Key messages

- The unacceptable health inequities within and between countries cannot be addressed within the health sector, by technical measures, or at the national level alone, but require global political solutions
- Norms, policies, and practices that arise from transnational interaction should be understood as political determinants of health that cause and maintain health inequities
- Power asymmetry and global social norms limit the range of choice and constrain action on health inequity; these limitations are reinforced by systemic global governance dysfunctions and require vigilance across all policy arenas
- There should be independent monitoring of progress made in redressing health inequities, and in countering the global political forces that are detrimental to health
- State and non-state stakeholders across global policy arenas must be better connected for transparent policy dialogue in decision-making processes that affect health
- Global governance for health must be rooted in commitments to global solidarity and shared responsibility; sustainable and healthy development for all requires a global economic and political system that serves a global community of healthy people on a healthy planet

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contemporary global governance landscape, power asymmetries between actors with conflicting interests shape political determinants of health.

We identified five dysfunctions of the global governance system that allow adverse effects of global political determinants of health to persist. First, participation and representation of some actors, such as civil society, health experts, and marginalised groups, are insufficient in decision-making processes (democratic deficit). Second, inadequate means to constrain power and poor transparency make it difficult to hold actors to account for their actions (weak accountability mechanisms). Third, norms, rules, and decision-making procedures are often impervious to changing needs and can sustain entrenched power disparities, with adverse effects on the distribution of health (institutional stickiness). Fourth, inadequate means exist at both national and global levels to protect health in global policy-making arenas outside of the health sector, such that health can be subordinated under other objectives (inadequate policy space for health). Lastly, in a range of policy-making areas, there is a total or near absence of international institutions (eg, treaties, funds, courts, and softer forms of regulation such as norms and guidelines) to protect and promote health (missing or nascent institutions).

Recognising that major drivers of ill health lie beyond the control of national governments and, in many instances, also outside of the health sector, we assert that some of the root causes of health inequity must be addressed within global governance processes. For the continued success of the global health system, its initiatives must not be thwarted by political decisions in other arenas. Rather, global governance processes outside the health arena must be made to work better for health.

The Commission calls for stronger cross-sectoral global action for health. We propose for consideration a Multistakeholder Platform on Governance for Health, which would serve as a policy forum to provide space for diverse stakeholders to frame issues, set agendas, examine and debate policies in the making that would have an effect on health and health equity, and identify barriers and propose solutions for concrete policy processes. Additionally, we call for the independent monitoring of how global governance processes affect health equity to be institutionalised through an Independent Scientific Monitoring Panel and mandated health equity impact assessments within international organisations.

The Commission also calls for measures to better harness the global political determinants of health. We call for strengthened use of human rights instruments for health, such as the Special Rapporteurs, and stronger sanctions against a broader range of violations by non-state actors through the international judicial system.

We recognise that global governance for health must be rooted in commitments to global solidarity and shared responsibility through rights-based approaches and new frameworks for international financing that go beyond

traditional development assistance, such as for research and social protection. We want to send a strong message to the international community and to all actors that exert influence in processes of global governance: we must no longer regard health only as a technical biomedical issue, but acknowledge the need for global cross-sectoral action and justice in our efforts to address health inequity.

The political nature of global health Global sources of health inequity

“We are challenged to develop a public health approach that responds to the globalised world. The present global health crisis is not primarily one of disease, but of governance...”¹

Ilona Kickbusch

The Commission on Global Governance for Health is motivated by a shared conviction that the present system of global governance fails to adequately protect public health. This failure strikes unevenly and is especially disastrous for the world's most vulnerable, marginalised, and poorest populations. Health inequalities have multiple causes, some of which are rooted in how the world is organised (panel 1).

Although the poorest population groups in the poorest countries are left with the heaviest burden of health risks and disease, the fact that people's life chances differ so widely is not simply a problem of poverty, but one of socioeconomic inequality. The differences in health manifest themselves as gradients across societies, with physical and mental ills steeply increasing for each step down the social ladder, along with other health-related outcomes such as violence, drug misuse, depression, obesity, and child wellbeing.¹¹ It is now well established that the more unequal the society, the worse the outcomes for all—including those at the top.^{11,12}

The WHO Commission on Social Determinants of Health recognised that societal inequalities skew the distribution of health. It concluded that “social norms, policies, and practices that tolerate or actually promote unfair distribution of, and access to, power, wealth, and other necessary social resources” create systematic inequalities in daily living conditions.¹³ In a groundbreaking analysis, the report showed how daily living conditions make a major difference to people's life chances. These conditions include safe housing and cohesive communities, access to healthy food and basic health care, decent work, and safe working conditions. They also include underlying factors: political empowerment, non-discriminatory inclusion in social and political interactions, and the opportunity to voice claims.

In our view, the report rightly characterised vast health gaps between groups of people as unfair, labelling them health inequities rather than inequalities. According to Margaret Whitehead, health equity implies that: “ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one

should be disadvantaged from achieving this potential, if it can be avoided. The aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level and quality of health, but rather to reduce or eliminate those that result from factors considered to be both avoidable and unfair.”¹⁴

Nation states are responsible for respecting, protecting, and fulfilling their populations’ right to health, but with globalisation many important determinants of health lie beyond any single government’s control, and are now inherently global.¹⁵ Besides local and national action, combating health inequity increasingly requires improvement of global governance. Although determinants of health exist at many levels—from individual biological variance to local and national societal arrangements—some determinants are tied to transnational activity and global political interaction. These global factors have received insufficient attention, perhaps because the causal linkages are complex and difficult to untangle, or because the implications can be controversial and unwelcome to some.

An abundance of scientific evidence shows the existence of a social gradient in relation to health inequalities and exposure to health risks.¹¹ We assert that health inequity requires a moral judgment—it must be considered unfair and avoidable by reasonable means. We argue that the norms, policies, and practices that arise from global political interaction (the global political determinants of health) and that unfavourably affect the health of some groups of people compared with others are indeed unfair. Some of these global political determinants could be avoided by improving the way global governance works. Tackling these global political determinants could thereby improve fairness in health.

The 2008 report of the Commission on Social Determinants of Health drew attention to political conditions that underpin unfair economic and societal arrangements. However, its analysis did not aim to address the underlying global forces, processes, and institutions that create the conditions that cause health inequity.¹⁶ As stated in a 2011 Comment in *The Lancet*: “An increased understanding of how public health can be better protected and promoted in various global governance processes is urgent, but complex and politically sensitive. These issues involve the distribution of economic, intellectual, normative, and political resources, and require a candid assessment of power structures.”¹⁷

Our response to this challenge requires the exploration of the plausible pathways through which transnational actions and global governance processes affect health equity. The sections that follow serve as a conceptual framework that guides analyses of a series of case examples. These examples have been selected from among important policy intervention areas in which global governance has failed to protect people’s health against “factors considered to be both avoidable and unfair”.¹⁴ We show how power asymmetry and global

Panel 1: Global health inequities

- About 842 million people worldwide are chronically hungry,² one in six children in developing countries is underweight,^{3,4} and more than a third of deaths among children younger than 5 years are attributable to malnutrition. Unequal access to sufficient, safe, and nutritious food persists even though global food production is enough to cover 120% of global dietary needs.²
- 1.5 billion people face threats to their physical integrity, their health being undermined not only by direct bodily harm, but also by extreme psychological stress due to fear, loss, and disintegration of the social fabric in areas of chronic insecurity, occupation, and war.⁵
- Life expectancy differs by 21 years between the highest-ranking and lowest-ranking countries on the human development index. Even in 18 of the 26 countries with the largest reductions in child deaths during the past decade, the difference in mortality is increasing between the least and most deprived quintiles of children.⁶
- More than 80% of the world’s population are not covered by adequate social protection arrangements. At the same time, the number of unemployed workers is soaring. In 2012, global unemployment rose to 197.3 million, 28.4 million higher than in 2007. Of those who work, 27% (854 million people) attempt to survive on less than US\$2 per day. More than 60% of workers in southeast Asia and sub-Saharan Africa earn less than \$2 per day.⁷
- Many of the 300 million Indigenous people face discrimination, which hinders them from meeting their daily needs and voicing their claims.⁸ Girls and women face barriers to access education and secure employment compared with boys and men,⁹ and women worldwide still face inequalities with respect to reproductive and sexual health rights.¹⁰ These barriers diminish their control over their own life circumstances.

norms limit the range of choice and constrain action, but also sometimes provide opportunities. Looking across the cases, we also identify systemic dysfunctions that hinder global governance from shaping positive determinants of health and from tackling the negative determinants. We urge responsible actors and opinion leaders to act, and we offer a range of actionable ideas for further consideration and development.

What do we mean by global governance for health?

The concept of global governance for health

With globalisation, transnational activities that involve actors with different interests and degrees of power, such as states, transnational corporations, and civil society, have increased. When interests conflict or major disparities in power exist, such transnational activities can have inequitable, negative effects on health, whether intended or not. In such cases, combating health inequity is both a global and a political challenge. Meeting this challenge requires action beyond the health sector or nation state alone, and demands improved global governance across all sectors. We follow Weiss and Thakur’s definition¹⁸ of global governance as: “The complex of formal and informal institutions, mechanisms, relationships, and processes between and among states, markets, citizens, and organisations, both intergovernmental and non-governmental, through which collective interests on the global plane are articulated, rights and obligations are established, and differences are mediated.”

This Commission is based on the concept of global governance for health. We regard health as a political challenge, not merely as a technical outcome. Global governance for health is achieved when we obtain a fair and equitable global governance system, based on a more democratic distribution of political and economic power that is socially and environmentally sustainable.¹⁹ Global governance for health is distinct from the concept of global health governance, which is defined as: “The use of formal and informal institutions, rules, and processes by states, intergovernmental institutions, and non-state actors to deal with challenges to health that require cross-border collective action to address effectively.”²⁰

Whereas global health governance is often used to refer to the governance of the global health system—defined as the actors and institutions with the primary purpose of health²¹—global governance for health refers to all governance areas that can affect health. Implicitly, it makes the normative claim that health equity should be an objective for all sectors. As such, the Commission does not focus on improving the governance of global health actors, but rather looks at how global governance processes outside the health arena can work better for health and for the continued success of the global health actors.

Political determinants of health

In our analysis, we are particularly concerned with global political determinants of health. This concept is not new. Many scholars have brought attention to the global and political nature of health and health equity.^{1,22–27} However, the concept has not been consistently defined. The Commission builds on existing work in defining the global political determinants of health as the transnational norms, policies, and practices that arise from political interaction across all sectors that affect health. This definition can include all rules that guide behaviour, from broad social norms to specific policies (eg, trade agreements) and practices (eg, unregulated activities of transnational corporations).

Political determinants operate in various ways. First, global norms guide societal interaction; they shape how problems or issues are viewed in global governance, and frame the types of solutions that are proposed, sometimes excluding discussion of alternative options. Second, political determinants such as rules of representation, voting, transparency, and accountability relate to who participates in global decision-making processes, and to how these processes are shaped by actors with different values, interests, and power. Finally, the outcomes of governance processes, such as formalised policies and agreements, shape practices at the national level.

The 1994 World Trade Organization (WTO) Agreement on Agriculture is an example of a policy that aimed neither to harm nor to promote health. WTO protection of subsidised agriculture in developed countries, however, reduced the competitiveness of small-scale

farmers in developing countries; it could thus be argued that the policy caused food insecurity, malnutrition, and associated health outcomes, and hence negatively affected health. As this example shows, a policy with no health-related aspirations can still severely affect health.

The WHO Global Code of Practice on the International Recruitment of Health Personnel exemplifies a policy intended to promote health equity. It aims to ensure a fairer distribution of health-care workers by limiting resource-rich countries from attracting health personnel away from resource-poor countries with the greatest health needs. Ultimately, this code, if effective, will contribute to the fairer distribution of health workers and improved access to health services. The political determinants of health are, as such, neither inherently good nor bad; rather the outcomes of these determinants have either positive or adverse effects on people’s health.

The global governance complex

Global political organisation

The present system of international political organisation is rooted in the post-World War 2 era when the victors established the UN, the Bretton Woods institutions (the International Monetary Fund [IMF] and the World Bank), and the General Agreement on Tariffs and Trade (precursor to the World Trade Organization [WTO]), to secure post-war order and prosperity. Each organisation was built on the principle of sovereign states coming together at will to address transnational issues.

The nation state has been the fundamental building block of the global polity since the 1648 Treaty of Westphalia, which established a set of sovereign European nation states. Nation states have proliferated, particularly over the past half century, largely due to decolonisation and the division of existing states into new, independent political entities. 51 member states joined the UN charter in 1945, increasing to 193 at present. However, the roles of nation states have changed as the importance of international organisations and groups of actors has grown. Market actors have entered the global governance arena, and private foundations, civil society organisations, and individuals have obtained more influence in global decision-making processes. States have formed groupings to pursue their interests, whether by region, such as the African Union or Association of Southeast Asian Nations, by level of development, such as the Organisation for Economic Co-operation and Development (OECD) or Group of 20, or by political orientation, such as the Non-Aligned Movement or the North Atlantic Treaty Organization (NATO). New issue-based constellations, such as the seven-country Oslo Ministerial Group on Health and Foreign Policy, might also help to shape the global policy agenda. Similarly, arenas and intergovernmental organisations to address specific issues have been created, such as WHO, the United Nations Environment Programme, and the International Labour Organization (ILO).

Despite recent trends towards greater regional and global political and economic integration, the sovereign state is an enduring feature of the global political structure, and remains the primary authority for the negotiation of global rules. On the one hand, sovereignty can limit the ability to govern globally by impeding the collective action required to respond to transnational challenges, ranging from volatile financial markets to climate change, and from regulation of transnational corporations to policing of organised crime networks.²⁸ Many of the instruments used to govern at the national level are not available at the global level, such as institutions for creating, interpreting, and enforcing laws, for taxing populations to provide public goods, for ensuring public safety and security, and for regulating markets.

On the other hand, a state's sovereignty can protect its population against global interference that is not rooted in due democratic process, and take action when global governance processes produce harmful outcomes. For example, international agreements often constrain what national governments are permitted to do, and can in some cases tie a government's hands when it comes to the protection or promotion of health—often referred to as shrinking policy space. In principle, a government could protect its policy space by choosing not to sign a treaty that it believes will be harmful for its population's health—as a sovereign state it cannot be forced to do so. In practice, however, other interests can be at stake such that health and social concerns are not given the priority they deserve.

Power asymmetry: the root cause of inequity

The Commission on Social Determinants of Health argued convincingly that the basic, root causes of health inequity lie in the unequal distribution of power, money, and resources.¹³ Power disparities and dynamics suffuse all aspects of life: relations between men and women, or old and young people, as well as between countries, firms, and organisations. Upheld by contemporary societal and global norms and policies, which are in turn maintained by those actors with the most power, power asymmetries persist.

In principle, states are political equals in the global system. In reality, power disparities remain vast, especially between the most advanced and the least developed countries. The skewed distribution of wealth between countries reflects their economic power: high-income countries account for only 16% of the global population, but two-thirds of global gross domestic product (GDP). The military spending of the USA exceeds that of any other country, and constitutes nearly half of total military spending worldwide.^{29,30} Although the “one-state, one-vote” decision-making rules of many UN bodies reflect the legal notion that sovereign states are equals in the international system, the choice of five permanent members of the UN Security Council and the weighting of IMF and World Bank votes by financial contribution reflect the greater influence of states with the greatest military and economic capacity.

Power asymmetries between countries are also manifest in the relation between donors and recipients of official development assistance. Recipients are almost entirely dependent on the goodwill of donors, either agencies or governments, with different interests and motivations. Donors have the power to choose which countries or actors to support and for which causes, for as long as they like. Additionally, in its present form, international aid is notoriously unpredictable and volatile, and is delivered through a multitude of channels including bilateral, multilateral, non-governmental, and public-private partnerships. As a result, governments in receipt of aid are wary of using it for recurrent expenditures, and the fragmentation and concomitant accounting and reporting requirements consume resources that do not necessarily contribute to the achievement of international aid goals. Although official development assistance is crucial in combating poverty, it is also a reminder of the major disparities in economic power between countries.

Private firms have an influential role in contemporary global governance. Large transnational companies wield tremendous economic power, which they can deploy to further their interests in global governance processes and global markets. The combined market capitalisation of the five largest tobacco corporations is more than US\$400 billion.³¹ For the five largest beverage firms the total is more than \$600 billion, and for the five largest pharmaceutical firms more than \$800 billion.³¹ These industries dwarf most national economies. Of 184 economies for which the World Bank reported GDP data in 2011, 124 had a GDP of less than \$100 billion. Although governments have the authority to regulate any private actor operating on their soil, in practice states face difficulties governing transnational corporations, not only because of their formidable economic power, but also because firms can change jurisdictions with relative ease to avoid or deter regulation—in other words, they seem to be beyond any one state's control. Although transnational corporations can yield enormous benefits by creating jobs, raising incomes, and driving technological advances, they can also harm health through dangerous working conditions, inadequate pay, environmental pollution, or by producing goods that are a threat to health (eg, tobacco).

Other non-state actors such as foundations also wield substantial economic power. The Bill & Melinda Gates Foundation has become one of the most influential players in global health. Its enormous contributions to global health initiatives have not only improved health for many, but also inspired financial contributions from other wealthy actors. In 2013, the Foundation had an estimated endowment of more than US\$36 billion.³² With its vast economic power, the Foundation has the power to set global agendas and to direct efforts and action via its grant-making priorities.³³



Joel Saget/AFP/Getty Images

For World Bank data see <http://www.data.worldbank.org>

In addition to economic and military power, normative power—the ability to shape beliefs about what is ethical, appropriate, or socially acceptable—has proven influential, even without huge material resources. International non-governmental organisations (NGOs), such as Oxfam and Médecins Sans Frontières, can wield considerable influence through their global networks, access to media, and public reputations. The media too can exert power to outrage the public and inspire political mobilisation, and through their editorial decisions they can drive issues up or down the global agenda.^{33–35} Scientific or expert bodies such as the Intergovernmental Panel on Climate Change can provide authoritative scientific evidence that puts pressure on governments to act.³⁶

In principle, people as citizens are represented by their nation states in global governance processes. However, groups of people such as the stateless, some Indigenous peoples, and other marginalised groups are very weakly represented, if at all. Furthermore, ordinary peoples' interests and values are sometimes poorly protected under the prevailing norms and practices that guide global governance—eg, by allowing non-state and for-profit actors (such as multinational companies) to exert illegitimate or undemocratic influence in global policy processes. However, to portray people as powerless recipients of governance decisions is to distort history. Health equity has successfully been promoted by popular mobilisation in social and political movements in low-income countries, such as Costa Rica, Cuba, and the Indian State of Kerala.¹⁶ These are examples of people's use of normative power on a national level; but also globally, new social movements continually spring up to call for action, challenging undemocratic processes, or protesting against unfair policies. The Occupy movement responded forcefully to growing inequality in 2011, and demonstrations emerged in Greece and Spain against harsh austerity measures. Mass demonstrations across Arab countries removed rulers in Tunisia, Egypt, Libya, and Yemen. Civil society groups have also mobilised transnationally and successfully deployed normative power to effect concrete policy changes—eg, convincing powerful armies to forgo weapons such as landmines and cluster bombs,³⁷ revising how development banks finance large dams,³⁸ and expanding space for public health in the global intellectual property regime.³⁹

Although power asymmetry is likely to be a permanent feature of global governance, power constellations can change. In recent years, emerging economies such as the BRICS (Brazil, Russia, India, China, and South Africa) and MIKT (Mexico, Indonesia, South Korea, and Turkey) countries have started to change established dynamics. Some emerging powers have taken more assertive positions in international arenas governing health, trade, climate, and security, or challenged governance arrangements such as decision making at the UN Security Council or voting shares at the IMF. New modes of economic, political, educational, and development cooperation

between developing countries are also emerging, challenging traditional dynamics of development aid.

Global social norms that affect global governance for health and health equity

Contesting norms

The context in which all human activity takes place presents preconditions that limit the range of choice and constrain action, but also sometimes provide opportunities. Some of these preconditions are global social norms. But global norms can change, and people can find unacceptable what they previously perceived as an absolute truth about the world. Women's suffrage and abolition of slavery show how new norms can contest existing ones, and offer a reminder that engaging in global norm contestation is a political act. Framing an issue so that it is viewed in a particular way is a central strategy for norm entrepreneurs. According to Bøås and McNeill,⁴⁰ framing is successful when the entrepreneur draws sufficient attention to an issue to get it on the political agenda. Finnemore and Sikkink⁴¹ propose a three-stage lifecycle for an idea to evolve into a norm. In the first phase of norm emergence, norm entrepreneurs attempt to bring attention to an idea and to persuade a critical mass of norm leaders, such as political actors, opinion leaders, and governments, to embrace the idea as a norm. Once a threshold of normative change is reached, a tipping point sets off the second stage, a norm cascade. During this phase, norm leaders attempt to socialise other actors to follow the norm. Finally, when the norm assumes a taken-for-granted quality, it has reached the internalisation stage: the norm is institutionalised and is no longer an issue for public debate.⁴¹

In their discussion of the Millennium Development Goals, Fukuda-Parr and Hulme⁴² argue that one major achievement of the 20th century was the emergence of the norm that “extreme, dehumanising poverty is morally unacceptable and should be eradicated”.⁴² But how do such norms fare in competition with other global norms?

Market dominance

We live in a global market system. This globalised system generates ever greater flows of goods, people, money, information, ideas, and values. These flows have been facilitated by privatisation, deregulation, and trade liberalisation policies, limiting the role of governments in the market economy. National governments have a role in encouraging and controlling these flows with varying degrees of success, because of the power of other, non-state actors such as private industry, banks, and civil society. In recent decades, this system has produced unprecedented growth that has increased material prosperity for hundreds of millions of people and greatly improved their health and wellbeing. But this growth has been uneven, both between and within countries.

As Sukhamoy Chakravarty⁴³ argued, that “the market is a bad master, but can be a good servant”. In addition to

increasing prosperity, economic growth can also have negative effects, both environmental and social. Within national boundaries, governments have designed policies intended to mitigate some of these negative effects, while maintaining benefits from positive ones. They have recognised that, at a minimum, a state is necessary to maintain the conditions of law and order in which a market can operate, and some countries have chosen to give the state a much more substantial role.

A key challenge for global governance is that the world market has evolved without the institutional underpinnings that have developed at state level to better govern markets in the public interest.⁴⁴ At national level, many governments have created institutions and adopted policies aimed at protecting their societies from the most harmful effects of liberalised markets. Such institutions do not exist at the global level: for example, there is no global social protection floor,⁴⁵ global competition authority, or global drug regulatory authority; nor are there global transparency laws, or global courts to enforce such laws were they to exist. With the absence of formal institutional mechanisms to regulate global markets, we fail to realise the potential for a fair distribution of the benefits of globalisation.⁴⁴

Thus, although health, social systems, and ecosystems have long been traded off against economic interests and market forces, the sustainability of such trade-offs is now increasingly questioned.²² The argument that environmental, social, and economic governance can no longer be pursued along separate tracks has started to feed into contemporary debate.⁴⁶

The biomedical approach

Recent years have witnessed a heavy emphasis on biomedical approaches to tackling global health challenges. The biomedical model is oriented towards the individual in illness and health. It focuses on the immediate biological, and sometimes behavioural, causes of illness and disease. The approach is largely curative—to repair the ill body—but includes preventive measures, such as mass immunisation programmes. The attraction of the biomedical model in global health stems from curative opportunities that have arisen from the substantial technological advances in medical treatment made during the past century.²² The model is also amenable to quantitative measurements, such as assessment of return on investment—eg, by counting the number of lives saved by an intervention.

Judging by the major global health gains of the past two decades,⁴⁷ this model has achieved important successes. For example, the total number of deaths among children younger than 5 years fell from about 12 million in 1990 to 6·6 million in 2012.⁴⁸ Maternal mortality fell by half from 1990 to an estimated 287 000 in 2010.⁴⁹ Treatment for HIV/AIDS in developing countries had reached more than 9·7 million people by 2012,⁵⁰ and the rate of new HIV infections has started to fall after decades of growth.

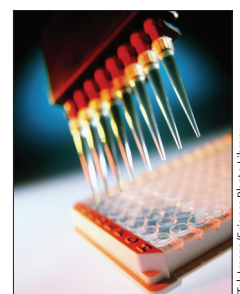
These positive developments are plausibly linked to increased domestic and international investment in health, including unprecedented growth in the political attention and resources dedicated to development assistance for health. Such assistance grew faster than official development assistance from 1990 to 2010, increasing by nearly five times, from US\$5·7 billion to \$28·1 billion.⁵¹ The sector benefited from a massive increase in investments from non-official sources, such as the Bill & Melinda Gates Foundation.

But health inequities persist, and are in many instances on the rise.^{52,53} The biomedical approach cures disease, but it alone cannot address the root causes of health inequity. Biomedical interventions should be accompanied by a broader understanding of health-depriving forces found in the global political economy. The deep causes of health inequity cannot be diagnosed and remedied with technical solutions, or by the health sector alone, because the causes of health inequity are tied to fairness in the distribution of power and resources rather than to biological variance. Yet, most international health investments tend to focus on specific diseases or interventions. Indeed, the contemporary focus on such solutions can frame global health as a managerial problem, devoid of the conflicting interests and power asymmetries that can distort the underlying mechanisms that determine health inequalities.⁵⁴ Construing socially and politically created health inequities as problems of technocratic or medical management depoliticises social and political ills, and can pave the way for magic-bullet solutions that often deal with symptoms rather than causes.

Human rights norms

For more than 60 years, a unified normative global framework relevant for health has been encapsulated in the 1948 Universal Declaration of Human Rights.⁵⁵ The Declaration articulates not only the right to life and to health, but also rights related to the major social and political determinants of health, including the right to an adequate standard of living and the right to participate in political life. These rights extend to all human beings irrespective of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status. Articulated further in the 1966 International Covenant on Economic, Social and Cultural Rights⁵⁶ and in the International Covenant on Civil and Political Rights,⁵⁷ and their respective optional protocols, these norms have the status of international law. The duty to realise these rights sits primarily with states, acting individually and cooperatively.

However, the internalisation stage of human right norms, including the right to health, remains weak and woefully incomplete. Although an international system is in place to monitor treaty compliance, both formal (eg, the UN Human Rights Council and other mechanisms such as the independent UN Special Rapporteurs) and informal (eg, reports from civil society and the media), in practice



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there is little that other states can or will do to compel an unwilling state to adhere to their human rights obligations. Additionally, few mechanisms are in place to effectively monitor and protect human rights across sectors and issue areas. For example, the UN Special Rapporteurs are mandated to respond to human rights complaints, draw government attention to human rights issues, and report annually on specific human rights themes to the Human Rights Council and the UN General Assembly. However, the Rapporteurs do not have any formal role in or institutionalised connection to multilateral bodies relevant for the specific human rights themes on which they report (health, food, water, migration, freedom of speech, etc). As such, the current multilateral structures do not maximise the potential of the Rapporteurs to strengthen respect for human rights beyond deployment of normative force. This limitation shows the inability of the global governance system to facilitate structures that lead to protection and promotion of health across all sectors.

These challenges in ensuring compliance with international human rights law across sectors and actors have attracted renewed attention through the post-2015 UN development agenda. The UN General Secretary⁵⁸ has reminded the world about the need to base a vision of the future in human rights and the universally accepted values and principles (such as accountability and transparency) encapsulated in the Charter,⁵⁹ Universal Declaration on Human Rights,⁵⁵ and the Millennium Declaration,⁶⁰ to achieve sustainable development. The vision must be agreed upon within strengthened partnerships for development, representing both state and non-state actors from all sectors of society.

Future challenges

Global social norms and the economic and political underpinnings of global arrangements and power distribution can change, and the global governance system itself is likely to evolve. New threats to health arise with environmental degradation, climate change, and unprecedented urbanisation. As thoroughly discussed in previous *Lancet* Commissions,^{61,62} these threats will profoundly change the global health picture. People's daily living conditions will change and new patterns of morbidity and mortality will emerge. New technology, especially within electronic communications, is being developed at an astonishing pace, and could provide new opportunities to combat health inequity. Important as explorations of these developments are, they are not within the scope of this report.

Aim of the Commission

The purpose of this Commission is to draw attention to the global political determinants of health. We maintain that it is the responsibility of nation states to respect, protect, and fulfil the right to health of their populations. However, when health is compromised by transnational forces, the response must be in the realm of global governance.

The tremendous health inequities that exist are morally unacceptable and “not in any sense a ‘natural’ phenomenon, but the results of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics”.¹³ The global, political nature of health has been recognised by many, from Rudolf Virchow in the 19th century, via the many individuals behind the 1978 Alma-Ata Declaration,⁶³ to the Commission on Social Determinants of Health.¹³ Notably, Foreign Ministers of seven countries (Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand) jointly developed and presented the 2007 Oslo Ministerial Declaration on Global Health,⁶⁴ which stated that health needs to be given a higher priority in the work of states on global political issues such as trade, intellectual property rights, conflict and crisis management, strategies for development, and foreign policy.

Discontent is growing among the public with what they perceive as an unjust global economic system that favours a very small elite with great wealth^{1,65} at the price of environmental and social degradation that negatively affects health equity. Contemporary debates on sustainable development after 2015 have recognised health as a beneficiary, contributor, and indicator of “people-centred, rights-based, inclusive, and equitable development”.⁶⁶ Between September, 2012, and March, 2013, the Global Thematic Consultation on Health in the Post-2015 Agenda⁶⁶ generated remarkable convergence with respect to placing governance at the centre of the new, universally applicable agenda for sustainable development, placing human rights principles—universal and indivisible—as the reference to drive policy coherence and mutual accountability. The outcome document of the 2012 UN Conference on Sustainable Development⁶⁷ expressed health as a precondition for, and an outcome and indicator of, all three dimensions of sustainable development: social, environmental, and economic.

We perceive this upwelling of collective efforts as an expression of a shared vision, an emerging global social norm: that the global economic system should serve a global population of healthy people in sustainable societies, within the boundaries of nature. The main ambition of this Commission is to add our voice and weight to push this norm towards its tipping point, by urging policy makers across all sectors, as well as international organisations and civil society, to recognise how global political determinants affect health inequities, and to launch a global public debate about how they can be addressed.

Political determinants at work

Examples from seven policy intervention areas

A globalised world relies increasingly on norms, rules, and regulations to govern transnational interaction in fields as diverse as trade and investment, financial and economic regulation, environment, labour, intellectual

The Commission, through a process of informed deliberation, selected cases that involved clear examples in which global policy interventions could reduce health inequity. These cases should be seen as illustrative examples rather than constituting a comprehensive overview of all policy areas in which global governance processes affect health and health equity.

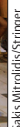
The financial crisis and health in Greece

Faced with a national financial crisis that created uncertainty about the country's ability to repay its debts, Greece accepted the bailout packages from the IMF, European Central Bank, and European Commission, including austerity measures that have had disastrous effects on the health and wellbeing of Greek citizens. Major cutbacks in government spending in the social sectors (health, welfare, and education) caused hundreds of thousands of public sector workers to lose their jobs or see their salaries frozen or reduced.⁶⁹ Since young people were hit especially hard, they have been named the crisis generation: in 2012, unemployment for people aged 15–24 years was 55.2% in Greece compared with an OECD average of 16.2%.⁷⁰ The country reports increased

Health consequences of austerity policies

With the advent of the global financial crisis, several analysts warned against the adverse effects of the crisis on social determinants of health.⁷²⁻⁷⁴ Because economic shocks are generally followed by reduced economic activity, tax revenues plunge. The present orthodoxy is to respond by cutting government expenditures to reduce budget deficits.⁷⁵ But this strategy does not take into account the adverse effects on health. In response to the global financial crisis, pressure for austerity led many countries to scale back their social protection systems, undermining population health.^{68,76,77} The conditions attached to bailout packages from the IMF, European Central Bank, and European Commission (eg, those received by Greece, Ireland, and Portugal) included reduced spending in social sectors, negatively affecting population health and wellbeing.^{68,69}

Contemporary events in many European countries mirror what has been happening in much of the developing world since the early 1980s: international financial institutions conditioned loans on structural adjustment programmes that included not only budget cuts to reduce fiscal deficits, but also a broader range of



measures to balance fiscal and trade deficits, deregulate the economy, and privatise state enterprises.⁷¹ These programmes involved implementation of the primary tenets of neoliberalism, including promotion of free markets, privatisation of public assets and programmes (including health care), so-called small government, and economic deregulation.⁷¹ Much research has shown that the effects of these programmes have been disastrous for public health.^{78,79} For example, studies have shown that structural adjustment programmes undermined the health of poor people in sub-Saharan Africa through effects on employment, incomes, prices, public expenditure, taxation, and access to credit, which in turn translated into negative health outcomes through effects on food security, nutrition, living and working environments, access to health services, education, etc.^{79,80} This pattern was also seen in other countries under loan conditionalities from structural adjustment programmes.⁷⁸

Political determinants of health and the question of accountability

The root causes of the Greek crisis are complex and still debated. However, clearly the precipitating events that led up to the national financial crisis and its responses had important transnational elements that placed them beyond the control of the Greek state. The Greek Government, under pressure from European Union leaders and foreign investors, had little leverage in negotiating the bailout packages from the IMF, European Central Bank, and European Commission. The bailout package was presented to Greek citizens as the only alternative to total collapse, and despite a series of major strikes and demonstrations against acceptance of the austerity packages, they were passed without any referendum after the Prime Minister had been forced to resign.⁶⁸

Two central questions are: were the austerity policies the only viable path to economic recovery? And were the adverse health effects avoidable by reasonable means? Evidence from past financial and economic crises shows that when fiscal policies that protect health and social welfare are implemented, economies can recover without adverse health outcomes.^{68,81–84} John Maynard Keynes argued that governments should, rather than cut spending, stimulate the economy during times of crises through increased spending, accepting a temporary increase in public debt that would be counterbalanced by surpluses when the economy became stronger.^{73,85}

Iceland offers an illustrative example of how investments, rather than cuts, in social sectors offer a viable path to recovery. Although Icelandic banks faced massive losses after the collapse of the US housing market, citizens decided against a government-financed bank bailout through a referendum, with 93% of the vote.⁶⁹ The government thus chose not to cover the bank's private losses with public funds, and did not have to seek bailouts from international financial

institutions or to adopt the austerity policies attached to them.⁶⁸ Against the advice of international lenders, the Government—among other measures—depreciated its currency, raised selected tariffs on imported goods, invested in social protection and labour-market stimulation, and retained high taxes on alcohol. As a result, the financial crisis has had little effect on the nation's health,⁶⁹ and economic growth has been robust in the ensuing years,⁸⁶ with unemployment steadily falling, and projected to be less than 5% in 2013.⁸⁷ The IMF has recognised that investments in Iceland's social protection programmes have been crucial to the country's economic recovery and the wellbeing of the population.⁶⁸

Despite such evidence, leading international political and financial figures are still promoting austerity as the favoured route to recovery.⁸⁸ This position raises questions about how much weight is given to people's health and wellbeing in economic policy making, and how the interests of lenders are weighed against borrowers in economic crises. It also raises questions about whether adequate mechanisms are available to demand accountability of international policy makers for the health effects of their decisions. European leaders have, for example, been raising concerns about the absence of accountability of the powerful European Central Bank, the leaders of which have been making bailouts conditional on austerity measures in several European countries.⁸⁹

Emerging reactions: social protection and alternative paths to recovery

As the detrimental effects of the crisis are becoming clear, new agendas are slowly beginning to emerge at the global level. Rising numbers of unemployed people worldwide—expected to approach 6% in 2013, up from a low of 5.4% in 2007⁹⁰—have sparked discussions in international organisations about the need for enhanced social protection and new systems of taxation.⁸⁵ The Commission on Social Determinants of Health identified social protection as one of the most powerful instruments to tackle health inequity at the national level.⁸⁵ Indeed, the fundamental importance of social protection is recognised by its inclusion in the Universal Declaration of Human Rights as a basic human right endowed to all individuals.⁹¹ However, currently, most of the world's poor people live, grow, and work without a social safety net. Olivier de Schutter, the UN Special Rapporteur on the Right to Food, has suggested three important reasons why comprehensive social protection systems are not accessible: tax revenues in poor countries are inadequate as a financial basis for the expenses involved; contemporary development models (such as structural adjustment programmes) supported by major international institutions include cuts in government spending and a shrinking of the state; and the population is susceptible to the same risks of

unpredicted shocks as the state, so that surges in demand for social protection coincide in time with reductions in state export and tax revenues.⁹¹

Debates are taking place at the ILO, WHO, and World Bank about the need to adopt the concept of a global social protection floor (panel 2). The ILO Conference in 2011, for example, discussed a possible non-binding international recommendation for a social protection floor to complement social security standards.⁴⁵ Arguments for a global layer of social protection in the form of cross-subsidies between countries, or transfers from wealthier to poorer countries, have also been put forward by several scholars.^{92–94} Such systems arguably could support national social protection mechanisms in poor countries, and help to cushion the effects of economic shocks.

Social protection has also emerged as a strong cross-cutting theme in international consultation processes for the post-2015 development agenda and the sustainable development debates that have followed on from the 2012 UN Conference on Sustainable Development in Rio de Janeiro. Advancing the cause of social protection globally will require alignment of interests in support of social protection as a shared responsibility and as a renewal of global solidarity. Similar ideas for health care are also emerging. In an interim report prepared for the UN General Assembly,⁹⁵ the UN Special Rapporteur on the Right to Health Anand Grover presented a framework for an approach to health financing based on the right to health. The report noted that the right-to-health obligations require states to cooperate internationally to ensure the availability of sustainable international funding for health. The Rapporteur recommended that steps should be taken to pool international funding for health, in the form of single or multiple coordinated pools, with treaty-based compulsory contributions from states.

Civil society organisations and movements in Europe and elsewhere have also started to speak out against the adverse effects of austerity policies on health equity.^{71,96} In line with their increasing influence in global financial governance, some developing countries are beginning to organise within the World Bank and IMF to move away from policies that reward deregulation. Several Latin American governments have also challenged neoliberal orthodoxies by becoming financiers in their own right; the Latin American Reserve Fund offers balance-of-payments support without requiring conditionalities of the sort demanded in structural adjustment programmes.⁹⁷ Recently, the IMF has recognised some of the limitations of austerity policies in terms of their adverse effects on economic recovery, health, and welfare.^{68,98,99}

Global governance for health: key challenges identified

With the present form of economic globalisation, cross-border financial flows have been liberalised, which has

Panel 2: The social protection floor

Endorsed by the UN Chief Executive Board and by the heads of state and government at the 2010 Millennium Development Summit, the social protection floor is defined as “an integrated set of social policies designed to guarantee income security and access to social services for all, paying particular attention to vulnerable groups, and protecting and empowering people across the life cycle”.⁴⁵ It includes guarantees of:

- Basic income security, in the form of various social transfers (in cash or in kind), such as pensions for elderly people and those with disabilities, child benefits, income support benefits, and employment guarantees and services for unemployed and working poor people.
- Universal access to essential, affordable social services in the areas of health, water and sanitation, education, food security, housing, and others defined by national priorities.

The social protection floor is a global concept. It should be the responsibility of each country to design and implement social protection schemes adapted to national circumstances.⁴⁵

had serious implications for health and health equity.¹⁰⁰ Markets are increasingly globally integrated, and institutions to govern volatile markets are missing. Capital has been freed from state control, and the policy space of governments to control capital inflows and outflows has shrunk. This development has, in turn, restricted the ability of governments to protect the health of their populations. As shown, the interests of governments in retaining the confidence of global financial markets have come into conflict with protection of health and welfare.

The austerity policies that were the conditions for bailouts from international financial institutions in several European countries are examples of how political determinants of health can flow from global governance processes. Powerful international policy makers are not held accountable for the health effects of their decisions, and adequate policy space is not provided to ensure that health concerns are considered in the design of financial bailout packages.⁷⁹

Knowledge, health, and intellectual property

High costs of new drugs

In March, 2013, the Intellectual Property Appellate Board of India upheld the country's first compulsory licence on a drug, sorafenib, used in the treatment of liver and kidney cancer, which had been issued 1 year earlier. Sorafenib is patented by the German pharmaceutical firm Bayer, which had priced a monthly treatment at about US\$5000 in India. Governments can issue compulsory licences to authorise the use of lower-cost generic versions of patented drugs, a safeguard that can protect the public against potential abuse of monopolies granted through the patent

system. Even countries that traditionally embrace strong intellectual property rights at times use the threat of a compulsory licence, as the USA did in 2001 for drugs against anthrax. India's compulsory licence authorised the firm Natco to produce a generic version of the drug and to pay Bayer a royalty of 6–7% of the generic price. Natco's version of the drug cost about \$160 for a monthly treatment, roughly 3% of Bayer's price.¹⁰¹

The sorafenib case is not only a story of one drug and one country's patent law, but also a flashpoint in a long-running global political contest over how certain types of health-related knowledge are produced, and who benefits. Because knowledge has had such a central role in improving health over the past century, global rules related to knowledge can profoundly affect health. A global community of scientists and scholars produces a huge volume of research on health policies, systems, and practices, as well as biomedical research that can be channelled into the development of technologies to combat disease and other causes of poor health. Total global public and private investment in health research was estimated at US\$240 billion in 2010, including health systems research and health technology research and development.¹⁰² However, although knowledge can in principle be made available to all as a global public good, in practice its benefits are often restricted through secrecy or intellectual property rights.

Effect of globalised intellectual property rules on health equity

One of the main sets of global rules that govern health-related knowledge production and access is the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). A central policy objective of protecting intellectual property is to incentivise the creation and disclosure of information and knowledge. Copyrights, which generally last 50 years after the death of the author, are intended to secure for authors (or their estates) the benefits of their labour. Patents, which generally last 20 years from the application filing date, are intended to provide inventors with a time-limited monopoly during which they can recoup their research investment, and thereby provide an incentive for private investment in research.

TRIPS requires countries to ensure a harmonised minimum level of intellectual property protection, based on the standards in industrialised countries, including: minimum 20-year patents in all areas of technology, including drugs; restrictions on the policy space for states to exclude specific technologies from patentability; and limits on permissible public interest safeguards in patent laws, such as compulsory licences.

Before TRIPS, many countries—including those in western Europe—had made special exceptions for food, drugs, agricultural technologies, and education in their national patent and copyright laws. But the introduction of patents on drugs, in many countries for the first time, enabled monopoly pricing for these products, raising

concerns about affordability, particularly for poor populations. Although the right to health includes access to essential drugs,¹⁰³ the adverse effect of patent monopolies on prices and availability of drugs has made it difficult for many countries to comply with their obligations to respect, protect, and fulfil the right to health.¹⁰⁴ Additionally, patents alone do not drive sufficient investment to counter diseases that predominantly affect poor people, because they do not offer a sufficiently profitable market; as a result, some diseases—or rather, some populations—are neglected.¹⁰⁵ This problem was characterised by the Global Forum for Health Research in the 1990s as the 10/90 gap,¹⁰⁶ on the basis of estimates that only 10% of research funding was spent on the major health needs of 90% of the world's population.

Copyrights can also raise the costs of accessing scientific publications. Library costs worldwide for scientific journals and monographs increased between 1986 and 2001, with libraries paying 210% more for 5% fewer periodicals.¹⁰⁷ In 2012, even one of the world's wealthiest academic institutions, Harvard University (Cambridge, MA, USA), announced that it could no longer afford to keep up with the spiralling cost of academic journal subscriptions, calling the situation “fiscally unsustainable and academically restrictive”.¹⁰⁸ Restrictions on access to knowledge can widen existing knowledge disparities, and restrict the access to information that is central to improvement of health.

Political determinants of health and market power

TRIPS shows clearly how economic power can shape global rule making, with far-reaching consequences for health. The negotiation of TRIPS in the 1980s and 1990s was driven by the lobbies of a handful of intellectual property-intensive industries in the USA, Europe, and Japan (mainly in pharmaceuticals, information technology, and entertainment). These lobbies persuaded their home governments to push for the inclusion of a binding multilateral treaty on intellectual property within the Uruguay Round of global trade talks. Developing countries were opposed to the inclusion of intellectual property in the package of trade agreements, because owners of intellectual property were predominantly based in rich countries. Globalisation of patent rules would create a net transfer of resources from poor countries to rich countries in the form of royalties, while simultaneously restricting access to the knowledge and technologies that could improve health and spur economic development. Nevertheless, a combination of carrots (concessions on agriculture and textiles) and sticks (bilateral trade pressure from the USA) led to the treaty being signed in 1994.¹⁰⁹

Although concerns about the health effects of TRIPS have been widely voiced by civil society and many developing countries,¹¹⁰ the agreement has become increasingly important with the continuing growth of the knowledge economy. TRIPS is nearly impossible to

amend because WTO rules require all members to agree on any changes—an unlikely outcome since the more advanced industrialised countries benefit handsomely from these rules. Thus, TRIPS shows how major power disparities shaped the initial rules of the game, and continue to perpetuate such disparity.

Emergence of access norms

Civil society organisations and governments mobilised in response to concerns about TRIPS and public health. The past decade has seen widespread normative change in approaches to patents on drugs, largely driven by responses to the HIV pandemic, particularly patents on antiretroviral drugs.³⁹ As a result, more than 90% of HIV drugs (by volume) now used in low-income and middle-income countries are generics.¹¹¹ The normative shift first became evident in the 2001 WTO Doha Declaration on TRIPS and Public Health, in which all WTO member governments agreed that TRIPS “does not and should not prevent members from taking measures to protect public health”.¹¹²

Governments have started to use more aggressively a range of policy approaches to counteract high drug prices, including TRIPS flexibilities such as compulsory licensing. New collaborative approaches have also been launched, such as the Medicines Patent Pool, which negotiates public health-oriented voluntary licences with patent-holding firms to authorise competitive generic production of HIV-related drugs for use in developing countries.

This access norm has extended to other diseases, such as tuberculosis, malaria, and the neglected tropical diseases, as shown by large donor initiatives (such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNITAID), pharmaceutical-company donation programmes and price discounts for low-income countries, and a well developed watchdog community of civil society organisations, scholars, and analysts. Research into neglected diseases has also increased sharply in the past decade, growing from almost no projects in 2000 to more than two dozen public-private product-development partnerships and about US\$3 billion in investment by 2011.¹¹³

Finally, recent years have seen increasing support for open access to scientific publications as new models of publishing have emerged. Open-access journals, first launched in the 1990s, publish peer-reviewed scholarly work online. About 5000 journals of this type are currently published, including professionally managed journals such as those run by the Public Library of Science and BioMed Central. Growing support for open-access publishing was reinforced by a groundbreaking 2007 law in the USA that requires grantees of the US National Institutes of Health, the world’s single largest funder of biomedical research,¹¹⁴ to make articles that result from research that the Institutes have funded available with open access within 12 months of



Rungroj Yangthirapap/Corbis

publication.¹¹⁵ Grantees can do so by publishing in an open-access journal or by making their article available in an online open-access repository. In 2012, the major research funders of the UK Government adopted a similar policy for publicly funded research, signalling growing momentum for open access to research publications.¹¹⁶ Open-access publishing has proved to be a viable model not only for journals, but also for chapters, academic theses, and entire books.

Despite some positive achievements, high prices of new drugs are still the norm (especially in emerging markets), the use of TRIPS flexibilities remains exceptional,¹¹⁷ and policy space to ensure access to health-related knowledge and to protect health within the trade and intellectual property regimes is under threat. Despite the Doha Declaration, many developing countries have been coming under pressure from intellectual property-exporting countries to enact or implement even tougher or more restrictive conditions in their patent laws than are required (so-called TRIPS-plus provisions) in bilateral or regional trade negotiations. Although they touch on many questions of public concern, trade negotiations are almost always conducted behind closed doors with almost no opportunity for public review of draft agreements. In principle sovereign states could reject TRIPS-plus provisions in trade negotiations, but in practice they can choose to compromise on public health concerns to secure other objectives, such as improved access to export markets. Furthermore, despite substantially increased investment in research into neglected diseases, the present global research system remains fragmented, inefficient, costly, and inadequately financed.¹¹⁸

Global governance for health: key challenges identified

A serious disparity in economic power and access to expertise exists between the industries and high-income countries that would benefit from the construction of a

stringent intellectual property regime, and the lower-income countries that would pay higher rents while having their access to knowledge restricted. Such power disparities are reinforced by the institutional rules of the WTO, which create a nearly insurmountable barrier to the amendment of TRIPS. The policy space to address health inequity in trade policy making is narrow, and the absence of transparency and public input into the negotiation of trade agreements that contain intellectual property provisions represent a serious democratic deficit. Finally, there is a dearth of appropriate institutions to ensure that sufficient research activities are directed at the greatest health needs.

Investment treaties and health equity

Regulations of cross-border investments

Cross-border investments have a major role in the global economy. For example, the estimated foreign capital stock of transnational corporations (the total assets of foreign affiliates) accounted for an estimated 10% of world's GDP in 2007. Global foreign direct investment was estimated at US\$1.3 trillion in 2012; a gradually increasing share has gone to developing countries, which now receive more than half of the total.¹¹⁹ The global system that governs foreign direct investment includes about 3100 investment agreements, including bilateral investment treaties and investment chapters in trade or economic partnership agreements.¹²⁰ Governments sign bilateral investment treaties to attract foreign direct investment and reassure investors that they will be treated fairly in a foreign jurisdiction. The purpose of bilateral investment treaties is to protect monetary flows, and they largely exclude concerns such as health, environment, and labour.¹²¹ Such treaties have recently been used by firms to challenge national health regulations. This development has raised concerns that transnational investment rules will discourage or undermine national health policies,

particularly when economically powerful, well resourced firms launch legal challenges against resource-poor governments.

Investment treaties constraining tobacco control measures

Tobacco use is estimated to have killed 100 million people in the 20th century, and will cause the premature death of one billion more in the 21st century unless consumption is reduced.¹²² Worldwide, consumption of tobacco products is increasing. Although smoking rates are falling in some high-income and upper-middle-income countries in response to a suite of tobacco control policies, this downward trend has prompted the global tobacco industry to seek new customers by shifting marketing efforts to low-income and middle-income countries, where nearly 80% of the world's one billion smokers now live.¹²² WHO has defined tobacco use as a marker of social inequity, because the health consequences of smoking are disproportionately borne by the most disadvantaged groups in society.¹²³

Governments have negotiated global rules to better govern tobacco use, encapsulated in the 2005 WHO Framework Convention on Tobacco Control (FCTC).¹²⁴ In recent years, they have started to implement this treaty by adopting tobacco taxes, bans or restrictions on advertising, health warnings on packaging, product regulations, and clean-air policies. Such policies have, however, faced national and international legal challenges as violations of countries' obligations under bilateral, regional, and multilateral trade and investment agreements.

After signing the FCTC in 2003, Uruguay started to introduce a range of tobacco control measures. In 2010, however, the tobacco company Philip Morris sued the government over a new regulation that required graphic warning labels on cigarette packs,¹²⁵ which are believed to be more effective than small, text-only health warnings.¹²⁶ Rather than bringing the case in Uruguayan national courts, Philip Morris went to the International Centre for the Settlement of Investment Disputes (ICSID), an international tribunal at the World Bank in Washington, DC, USA, established to adjudicate conflicts between private firms and states that have signed investment treaties. A parent company of Philip Morris in Switzerland used the Switzerland–Uruguay bilateral investment treaty to bring the case. Bilateral investment treaties usually include investor–state dispute-settlement provisions that allow foreign firms to legally challenge national regulations that reduce their return on the investment.

The Uruguayan case is not isolated. The number of legal disputes brought by companies against states for violation of investment treaties has risen sharply in the past two decades. Many cases related to health and environmental legislation have been brought under bilateral investment treaties and the investment chapters of trade treaties such as the North American Free Trade Agreement (NAFTA).¹²⁷ Philip Morris also launched a legal challenge to Australia's regulation requiring plain



packaging of cigarettes under a bilateral investment treaty between Hong Kong and Australia. The company also brought a case against Canada in 2001 under NAFTA, responding to a government proposal to prohibit the terms “light” and “mild” on cigarette packs.

Tobacco is not the only health-related issue to be raised in investor–state dispute-settlement proceedings. In 2012, the pharmaceutical company Eli Lilly challenged Canada’s patent standards through an investor–state dispute after the government invalidated its patent on a drug.¹²⁸ The company argued that patents should be regarded as protected investments and has sued the government for US\$500 million in compensation.¹²⁹

Political determinants of health and global governance dysfunctions

Several attempts to create global regulations for foreign direct investment have failed. Most recently, the OECD’s proposed Multilateral Agreement on Investment and proposals for international rules on investment during the WTO Doha round failed, largely because of opposition from developing countries and civil society groups that feared they promoted the rights of investors over those of sovereign states.¹³⁰ However, the resulting web of transnational rules has been developed under even less scrutiny than the proposed multilateral framework, leading to a fragmented system of bilateral and regional agreements, within which health is given little consideration.^{130,131} When faced with a legal challenge under a bilateral investment treaty brought forth, for example, by a transnational corporation, governments can revise their regulations, pay compensation, or decide not to adopt some policies at all to avoid costly litigation.

Furthermore, concerns have been raised that arbitration processes suffer from a serious democratic deficit. The existence of cases, arguments, and final decisions can all be kept confidential, such that no public scrutiny of cases is possible, even when they touch on questions of major public concern. Additionally, questions have been raised about the legitimacy of a system in which three judges—who often come from law firms that also represent clients at such tribunals—decide behind closed doors on crucial issues of public policy. In both design and execution, the dispute-settlement process of investment agreements reflects major power inequalities between those with financial resources (investors and firms) and governments, particularly governments of developing countries.

Challenging existing regulations

When Philip Morris first challenged its regulation, the Uruguayan Government initially considered conceding and changing its law. However, the global tobacco control community mobilised to facilitate access to expert legal services to support the government, which is now fighting the challenge at ICSID.¹³² The normative weight of the FCTC and the strong global civil society networks

that have been built to support its implementation provided a counterweight to the investment regime.

The Australian Government recently defeated a legal challenge by Philip Morris against its plain-packaging law at the Australian Supreme Court, although the international challenges under the investment treaty and through the WTO are continuing. In 2012, the South African Government announced that it would not renew 13 bilateral investment treaties it had signed with European Union member states, because European firms had used them to challenge its domestic labour laws.¹³³

Global governance for health: key challenges identified

The cases of challenges to tobacco control measures show governments are sometimes able to defend their public health regulations, even in the face of unequal financial and legal resources, and that sovereign states can, in some cases, withdraw from international agreements that unacceptably impinge on national policy space. However, such examples are rare. The global norms that safeguard market interests supersede other concerns, as shown by the proliferation of bilateral investment treaties and increasing disputes between investors and states. The patent case in Canada, for example, will indicate the extent to which investor–state dispute settlement can be applied to new fields. Repeated calls for greater transparency in settlement of investment disputes have produced few substantive changes in how tribunals are run.

The global investment regime shows how public health concerns can be subordinated to the interests of private firms. Major power disparities exist between multinational tobacco firms and developing countries in their access to the costly legal expertise required to fight a dispute at an international investment tribunal. Furthermore, firms can reap benefits from the absence of transparency in such proceedings, which shields them from public scrutiny and reputational harm.

Several shortcomings of the global governance system contribute to this situation. First, a democratic deficit arises from the confidential nature of dispute-settlement proceedings. Second, whereas strong institutions exist for the protection of investors’ rights, mechanisms to hold investors accountable for the negative health effects that can result from their legal challenges are weak. Finally, investment agreements have proven difficult to reform: despite some progress, calls to substantially increase the transparency of the system have proven difficult to implement.¹³⁴

Food and health equity

The political nature of nutrition

As Olivier de Schutter, the UN Special Rapporteur on the Right to Food, has noted: “One in seven people globally are undernourished, and many more suffer from ‘hidden hunger’ of micronutrient deficiency, while 1·3 billion are overweight or obese”.¹³⁵ De Schutter points out a core

paradox in the present global situation with respect to food and nutrition. While billions starve and go hungry, millions of others have obesity-related illnesses. At the same time, global food production is increasing and currently covers 120% of global dietary needs.^{2,136}

The conditions of hunger and obesity within a country are subject to various local, national, and global political processes. As Amartya Sen¹³⁷ argued three decades ago, nutritional status is not determined solely by the availability of food, but also by political factors such as democracy and political empowerment. The politics that generate and distribute political power and resources at local, national, and global levels shape how people live, what they eat, and, ultimately, their health.¹³⁸ The global double burden of overnutrition and undernutrition is thus one of serious inequity.

Food insecurity and health inequity

Food security is defined as physical, social, and economic access by all people at all times to sufficient, safe, and nutritious food that meets their dietary needs and food preferences for an active and healthy life.¹³⁹ National food systems are increasingly affected by activities at the global level, often putting additional pressures on the food security of poor households. Analysts have pointed to a range of global-level factors that have potential effects on food security, including agricultural trade agreements,¹⁴⁰ price volatility,^{141,142} financial speculation,^{143,144} replacement of domestic food crops with export crops,^{143,145} and marketing of unhealthy foods by large corporations.¹⁴⁶

Changes in the global food system are major drivers of the double burden of malnutrition, wherein obesity paradoxically coexists with hunger and undernutrition.¹⁴⁷ Overconsumption of energy-dense fats and sugars leads to obesity, which is now surpassing tobacco as the biggest preventable cause of disease burden in some regions.¹⁴⁸ Because highly processed, energy-dense foods are consistently cheaper in terms of energy content for a given price,¹⁴⁹ social and economic conditions result in a social gradient of diet quality.¹⁵⁰

Most people who live on less than US\$1.25 daily worldwide reside in rural areas where they depend largely on agriculture.¹⁵¹ Global food-price volatility therefore affects them as both consumers and producers. Recent years have witnessed increased volatility in global food prices, most notably in 2007–08 when the price of basic food staples increased drastically, rising by 70% from their 2002–04 baseline.¹⁵² As a result, the number of people living in extreme poverty rose from 130 to 150 million,¹⁵³ and food riots broke out in several developing countries around the world, threatening the stability of several governments. At least 40 million people were driven to hunger and food insecurity as a result of the 2008 food-price crisis. In 2008, the total number of hungry people worldwide reached 963 million.¹⁵⁴ People in the poorest countries bore the brunt of the hikes in food prices.

Food insecurity in a globalised economy

Many low-income countries liberalised their economies in the 1980s, often as fixed conditions for foreign loans. Agricultural trade took place largely outside of the multilateral system until the 1994 Agreement on Agriculture brought food under the umbrella of the WTO. The agreement obliged WTO members to increase market access for agricultural products, and to reduce domestic and export subsidies. Although many poor countries expected to gain access to lucrative markets in high-income countries with the liberalisation of agricultural trade, their expectations were often unfulfilled. High-income countries already had an advantage when the agreement came into force, since they were the only states that already had substantial export subsidies in place, which they were only obliged to reduce in value terms, whereas many developing countries did not have subsidies in place, and could not introduce any after the agreement came into force.¹⁵⁵

Continued agricultural subsidies have allowed the USA and European Union to export food surpluses to low-income and middle-income countries, causing the displacement of local food production and increasing the dependency of smallholders on food imports, often making them more food insecure.^{76,155} Developing countries are also increasingly obligated to further lower tariffs, export subsidies, and domestic agricultural support, and to open their markets for foreign direct investment, gradually increasing the exposure and vulnerability of local farmers to food-price volatility.¹⁵⁶

Trade liberalisation has also contributed to the escalating obesity pandemic.¹⁵⁷ The deepening penetration of food markets in middle-income countries by multinational food corporations has been associated with increasing intakes of unhealthy commodities such as soft drinks and processed foods, contributing to rising rates of non-communicable diseases.^{146,149} This shift in diet patterns and changing nutritional challenges have come about as corporate value chains increasingly integrate production, transport, and distribution of food, with wide reach from farmers to consumers. As global supermarkets now rapidly expand in Latin America, Asia, and Africa, it becomes increasingly difficult for smaller food producers to gain access to the world food market.¹⁵⁸ Domination by a few powerful actors with increasing bargaining power could result in an undifferentiated global food market in which consumer welfare is measured by price rather than by nutritional value or health effect.¹⁵⁸

Rules that govern issue areas other than trade also have an effect on food—eg, international agreements to promote biofuel cultivation, or liberalisation of national investment rules, allowing large-scale transnational land leases. Over the past decade, we have witnessed an increase in transnational corporations investing in countries where natural resources such as land and water are abundant and where local markets are poorly

integrated in the global economy.^{159,160} As a result, these actors have increased their control of global food production and supply.

The global food crisis of 2007–08 increased the political attention paid to the ways in which deficiencies in the governance of food affect global food security, and emphasised the adverse effects of unregulated financial markets. Some commentators have argued that the price hike in food crops reflected changing food demands in emerging economies in favour of meat (necessitating increased production of animal feed) and increased demand for biofuels, leading to a fall in the production of food crops.¹⁶¹ However, research has shown that excessive financial speculation in the world grain market accelerated the crisis.^{142,162} As investors faced a downturn in other financial markets, they entered the futures commodity markets on a massive scale.¹⁴⁴ Conditions whereby speculation was allowed to occur in essential food commodities largely exacerbated the effect of regular market supply and demand mechanisms. As such, although the promotion of biofuels and changing food demands in emerging economies were catalysts that set off a giant speculative bubble, the increased trade in futures commodity markets was the underlying reason for excessive food-price volatility.^{142,163}

Power inequality and diverging interests

Many different actors are responsible for various aspects of food security: national authorities, landowners, multilateral organisations, transnational industries, and regulatory authorities in sectors such as health, agriculture, and trade. Together they constitute a complex of diverging and overlapping interests,^{164–166} with unequal power and thus differentiated ability to influence structures and processes.

Generally, institutions, agreements, and laws related to finance and trade are more powerful than those that deal with food security.^{164,166,167} For example, the ability of host states (ie, the nation state where the investor is registered) to force investors to run their investments in ways that do not violate food security is undermined by overprotection and under-regulation of the investor.¹⁶⁸ Furthermore, no supranational mechanisms exist to mediate between the normative orientation of the WTO, where the primary objectives are trade liberalisation and little state intervention, and the UN human rights system, wherein the primary objectives are to obligate states to respect and fulfil human rights (such as the right to food), particularly those of the most vulnerable populations.¹⁶⁸ Additionally, reform of existing rules on agricultural trade to better protect health is difficult, in view of the decision-making processes at the WTO requiring consensus among all member countries.

Traditionally, political participation in the global governance of food and agriculture by people affected by agricultural and food policies (eg, smallholder food



Reuters/Giampiero Spisito

producers, marginalised communities, and Indigenous people) has been low.^{169,170} By contrast, market actors such as transnational corporations and financial speculators are increasingly expanding their policy space and influence on global decision-making processes, with no accountability with respect to the international laws protecting vulnerable populations.^{155,171} The international peasant farmers movement La Via Campesina argues that smallholder farmers should have a more dominant role in agricultural policies, stating that this enhanced role only can be achieved if local communities have better access to, and control over, productive resources, and more social and political influence in international regulatory processes that affect food security.^{169,172}

Reforming the global governance architecture

The failings of global governance of food markets exposed by the 2007–08 price crisis created a sense of urgency for institutional reform.¹⁶⁴ The global food security architecture seemed fragmented and uncoordinated, reflecting fundamental disagreement at the global level about how best to attain food security. In 2008, the UN Chief Executive Board established a high-level task force on the global food security crisis, involving UN agencies, the World Bank, IMF, OECD, and WTO. The task force produced a Comprehensive Framework of Action on Food Security, calling for two policy tracks: social protection systems, and policies to stimulate longer-term productive capacity, resilience, and earning opportunities through investments that prioritise the interests of smallholder farmers.

Another noteworthy initiative was the 2009 reform of the Committee on World Food Security, originally set up as an intergovernmental committee at the FAO in 1974. The inclusive reform process has arguably transformed

the Committee from an ineffective discussion forum to a more inclusive and authoritative policy forum.¹⁶⁴ The Committee now provides for meaningful participation of non-state actors alongside member governments and pays particular attention to organisations that represent small food producers and poor urban consumers.¹⁶⁴ Additionally, a high-level panel of experts on food security and nutrition was established, including civil society actors, academics, and researchers. This independent scientific body puts forward evidence-based proposals, drawing from the knowledge of a wide range of experts, and is a key part of the Committee. These efforts signify increased recognition of the need to address the structural causes of the flawed global governance of food.

Global governance for health: key challenges identified

Powerful actors make decisions with substantial implications for food security. However, when neither food security nor human health are among their core objectives, health can, and often does, suffer from the consequences of their activities. Glaring disparities in economic power exist between poor households that spend a large proportion of their incomes on food and poor countries that are net food importers on the one hand, and investors and firms that benefit from speculation on global food commodity prices and net food exporters on the other. New institutions are needed to regulate speculation on food.^{144,173}

The negative effect of global political determinants on food security shows serious deficiencies within the global governance system: no single global institution has the authority and responsibility to ensure food security; reform of existing rules on agricultural trade to better protect health is difficult; and mechanisms to hold powerful actors accountable for the health-related effects of their decisions do not exist.

Conduct of transnational corporations and health

Toxic waste in Côte d'Ivoire—who is responsible?

Large companies do business on a global scale and dominate the production and marketing of the world's goods and services. This situation affects the lives of individuals and communities in numerous ways: their conditions of employment (in factories, fields, mines, etc); their consumption patterns (eg, through advertising); and not least, their environmental conditions.

Toxic waste dumping in Abidjan, Côte d'Ivoire, shows clearly how under-regulation of transnational firms can negatively affect health. On the morning of Aug 20, 2006, residents of the west African city woke to a foul smell. Toxic waste had been dumped in at least 18 places around the city, close to houses, workplaces, schools, and crops. People started to get nausea, headaches, breathing difficulties, abdominal pains, stinging eyes, and burning skin.¹⁷⁴

The situation in Côte d'Ivoire was created by the interplay of global and national determinants: the toxic waste was carried by the ship Probo Koala, leased by the Europe-based commodity trading company Trafigura. The company had sought firms in many countries to process the toxic waste at a price it was willing to pay. Its efforts spanned the Mediterranean, the Netherlands, Estonia, Nigeria, and ultimately Côte d'Ivoire, where it contracted a company that had neither the experience nor the capacity to deal with this type of waste.

When the incident occurred, Côte d'Ivoire was emerging from a serious political and military crisis in which institutions of government had been severely disrupted. Health centres and hospitals were soon overwhelmed and international agencies were drafted to help overstretched local medical staff in the subsequent weeks. Less than 2 months later, health centres had registered more than 107 000 people as having been affected by the waste. National authorities attributed at least 15 deaths to the exposure.¹⁷⁴ No health monitoring or epidemiological studies have been undertaken to assess the medium-term to long-term health effects. Complete information about the composition of the waste has not been made public. Major questions loom: why did this happen where it did, and who should be held to account?

Under-regulation of transnational activities and effects on health equity

Serious concerns have been expressed about the effect of transnational corporations on human wellbeing, especially in jurisdictions where government regulatory authority is weak. A range of voluntary regulations and corporate responsibility initiatives have been launched in several industries to address this governance gap. Nevertheless, concerns persist that some firms exploit cross-country differences in regulations to maximise profits.

The toxic waste dumped in Abidjan is a case that shows how systems for global governance and



Legnan Koula/epa/Corbis

enforcement of international law have failed to keep up with companies that operate transnationally. Trafigura was able to fully exploit legal uncertainties and jurisdictional loopholes, with devastating consequences. The relation between under-regulated activities of transnational corporations on the one hand, and health on the other, is not confined to the handling of toxins. Extractive industries operating in oil, gas, and mining have long been recognised as some of the most damaging to environment, health, and livelihoods.¹⁷⁵ For example, mining causes high occupational mortality.^{175–177} Accidental poisonings and exposure to toxins across industries kill some 355 000 people annually,¹⁷⁸ with developing countries accounting for two-thirds of exposure-associated deaths.^{179–181}

The costs of extractive industry activity are not borne only by workers, but also by communities and their environment. In the case of mining, toxic contaminants such as arsenic, heavy metals, acids, and alkalis can be discarded into the environment, ending up in water, soil, and the food chain. Through industrial activities in agriculture and manufacturing, harmful pollutants can be released directly into the environment.¹⁷⁶

Foreign direct investments and policy space

Foreign direct investment is widely regarded as an important vehicle to advance economic growth and development.¹⁸² Proponents argue that deregulation and foreign direct investment are good for health, because liberalisation leads to economic growth and generates new wealth, which in turn is expected to lift more people out of poverty. However, Anand and Sen¹⁸³ warn that the effect could instead be increasing inequality and deterioration of human welfare. A complex system of global rules and regulations has been put in place to protect and promote the flow of capital, but it largely excludes public policy issues such as health, environment, and labour.¹²¹

For host governments, the activity of transnational corporations can be used to help them to advance economic growth, and they might therefore support and encourage firms to expand through fiscal incentives to attract foreign direct investment. Countries have also been seen to deregulate labour and environmental standards, and to limit tax or corporate tax collection. Consequently, they limit their own policy space.

Civil society groups, including NGOs, trade unions, local communities, and Indigenous people, have been important critics of the under-regulation of transnational corporations. They have brought attention to and documented the suffering of affected communities, exploitation of natural resources, environmental degradation, and deteriorating labour standards. They have called for increased policy space to pursue legitimate social policies in host countries. They have stressed the need for transparent agreements and the inclusion of environmental and core labour standards in negotiated treaties.^{184–186}

International law, norms, and monitoring initiatives

International laws and norms have an important, though incomplete, role in regulating the conduct of transnational corporations. Although communities in host countries are often poorly protected against the operations of transnational corporations, foreign direct investment is protected by negotiated treaties between states and firms, ensuring protection of the investor.¹⁷⁵ Disputes can be brought to ICSID, which provides conciliation and arbitration of investment disputes between contracting states and nationals of other contracting states. Traditionally, foreign direct investment treaties protect investments on foreign soil and thereby favour home countries and firms. Binding regulations for compensation for harm done on foreign soil are, however, less developed.

The 2011 UN Guiding Principles on Business and Human Rights¹⁸⁷ clarified the universal responsibility of firms to respect human rights and to provide remedies when rights are violated. They have been widely endorsed by governmental and industry bodies, but are non-binding.¹⁸⁸ Binding international laws, such as the 1989 Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal,¹⁸⁹ or the 2013 Minamata Convention on Mercury,¹⁹⁰ are intended to protect human health and the environment against the harmful effects of industrial activity. However, even when such conventions are widely adopted, without an authoritative body to monitor and enforce compliance, their implementation remains at the discretion of individual states.

National courts can sometimes exert extraterritorial authority to strengthen accountability for harm committed elsewhere. An example is the Alien Tort Claims Act (ATCA) in the USA,¹⁹¹ which has been used by advocates for several decades to bring cases in US courts for harm committed on foreign soil; however, a recent decision of the US Supreme Court has dramatically limited ATCA, raising serious questions about whether it can function as an effective mechanism for transnational accountability.¹⁹² At the international level, only a thin patchwork of international courts exists, covering a restricted set of issues, and with very little jurisdiction over corporations. In an effort to move beyond purely voluntary action, schemes for the rating, labelling, and independent monitoring of the activities of transnational corporation have been implemented. The Publish What You Pay network is an example of a strategic coalition of civil society organisations pushing for transparency and accountability of extractive industries.¹⁹³ Similarly, the global Extractive Industries Transparency Initiative¹⁹⁴ promotes improved governance in resource-rich countries through full publication and verification of company payments and government revenues from oil, gas, and mining. Other attempts to improve corporate accountability include socially responsible investment, which mobilises financial resources of large institutional investors, thereby influencing the business practices of transnational corporations.

Global governance for health: key challenges identified

Many efforts have been made to improve the global governance of transnational corporations, but as the Trafigura case shows, the existing regulatory framework remains inadequate to protect health. Vast power disparities exist between the multinational firms that make decisions about where to invest or establish production facilities, and the poor countries that seek to attract such investments by offering low costs through, among other methods, lax enforcement of labour, environmental, and social regulations.

The challenge of regulating transnational corporations in a globalised economy shows several dysfunctions in the global governance system, including: the paucity of rules and codes of conduct that reach beyond the voluntary level; weak mechanisms for accountability of transnational corporations to the people whose lives and health are most directly affected by their actions; weak institutions for enforcing international norms, laws, and standards when they are violated by transnational corporations; and the absence of institutions to ensure that competition for foreign direct investment between states does not lead to outcomes contrary to public interest.

Irregular migration and health

Failure to protect the health of the most vulnerable

The lived experience of irregular migrants (panel 3) is often a barrage of social, economic, psychological, and physical vulnerabilities. The experiences of the growing number of such migrants emphasise a fundamental normative and institutional gap in global governance. Despite existing international human rights treaties that should, in theory, protect migrants irrespective of their legal status in a country, in practice, states take great leeway with respect to how such migrants are treated.¹⁹⁶ Because of the difficulty in enforcing international law, forcing states that are not meeting their international human rights obligations in how they treat migrants to comply is essentially impossible.

An example of an irregular migrant's experience with Norway's health system shows clearly how constraints posed by national policies lead to a failure to protect the

health of the most vulnerable people.¹⁹⁷ A 42-year-old man travelled for hours from a rural refugee reception centre in southern Norway to attend the health clinic for undocumented immigrants in Oslo. The man was HIV-positive, but the complaint that brought him to the clinic was a constant, unbearable hip pain. At the refugee reception centre, a doctor examined him and referred him for an orthopaedic assessment at Oslo University Hospital, where specialists diagnosed joint failure and referred him for hip replacement surgery. However, the hospital's surgical department refused to do the procedure, because his application for asylum had been turned down, hence he found himself with irregular status.

The hospital that refused his surgery was the same one where he received outpatient treatment for HIV, free of charge and irrespective of legal status. HIV treatment falls under Norway's Communicable Disease Act, which grants access to free medical assessment, diagnosis, and treatment to anyone in the country, irrespective of legal status. Were the hospital to treat his hip, however, it would not be reimbursed for the cost.¹⁹⁸

Rights of irregular migrants not respected

Although data for the health of migrants, especially irregular migrants, are scarce, findings from several studies suggest that migrants generally become more vulnerable to ill health than non-migrant populations during the transit between their country of origin and their destination, and during their stay in destination countries. Barriers to movement created by states to control migration and the abundance of smugglers and traffickers have made irregular migration a dangerous experience.¹⁹⁶ During their stay in destination countries, migrants can become more vulnerable to some communicable diseases (such as tuberculosis, HIV/AIDS, and hepatitis B), some non-communicable diseases (such as diabetes), occupational diseases, poor mental health, and maternal and child health problems, compared with non-migrants.^{199,200} This increased vulnerability to ill health is closely related to their working and living conditions and to their legal status in the destination countries, which determines their access to social and health-care services.^{199,201,202}

Often, migrants are disproportionately subject to poor socioeconomic status via their migration status, ethnicity, and processes of social exclusion,^{203,204} and are vulnerable to exploitative working conditions in which regulations are not enforced.^{195,205} Furthermore, in many countries undocumented migrants are largely excluded from health care and social services,²⁰⁶ leaving irregular or undocumented migrants with poorer health than migrants with legal status. For example, in the European Union, most countries offer only emergency care to undocumented migrants. Additionally, fear of deportation further limits migrants' use of health care.

The world has roughly 214 million cross-border migrants, representing 3·1% of the global population.²⁰⁷

Panel 3: Defining irregular migrants

An irregular (or undocumented) migrant is a person who does not have legal status in a transit or host country. The term refers to people who entered the territory of the state without authorisation (eg, through smuggling), and to those who entered the country legally and subsequently lost their permission to remain. Loss of legal status can happen, for example, because the migrant has overstayed a visa or residence permit, been denied refugee status, or because an employer has arbitrarily withdrawn an authorisation to work that is tied to immigration status.¹⁹⁵

A range of complex, interrelated factors, including conflict, environmental disasters, and socioeconomic deprivation, can drive people to leave their countries of origin for unknown territories and jurisdictions. Many such people have been referred to as survival migrants, since they migrate because of desperate economic and social situations, but do not conform to the 1951 Refugee Convention's definition of a refugee.¹⁹⁶ Since the 1980s, the number of so-called irregular migrants has increased rapidly, with irregular migration becoming one of the fastest-growing forms of migration worldwide.²⁰⁸ Information from regularisation programmes and other sources suggests that there might be 30–40 million irregular migrants worldwide, or 15–20% of all international migrants.^{209,210}

The increase in irregular migration reflects policy choices and legal definitions poorly adapted to present realities, and not merely a change in migration patterns. Despite the need for low-skilled and semiskilled workers in many societies, states tend to encourage and legitimise skilled migration and limit or delegitimise low-skilled labour migration because of political hostility based on a fear that low-skilled migrants threaten domestic workers' jobs and working conditions.¹⁹⁵

Although the economic contributions of irregular labour migrants might be recognised, irregular labour migration is not a trend readily welcomed by destination countries, and substantial debate over the assignment and assumption of responsibility for irregular migrant workers persists.¹⁹⁵ The flow of low-skilled migrants to more developed regions is therefore often channelled by clandestine means because of the absence of migration categories that allow for legal entry.²¹¹ Once in host countries, irregular migrants are granted only minimum rights, and have few mechanisms for securing them. As seen in the Norwegian example, the rights of irregular migrants are respected only in case of emergencies, or insofar as doing so also directly benefits host populations, such as by ensuring treatment of infectious diseases. Beyond this basic provision, access to care is restricted and mainly provided by charity organisations.²⁰⁶

Inadequate adoption of human rights norms

The transnational flow of irregular migrants challenges in what sense human rights—and the human worth and dignity reflected in them—can be said to be universal. Ensuring respect for the universal human rights of cross-border irregular migrants and implementation in national legislation is a challenge without an authoritative institution to set standards. Although international human rights law and international migration law put legal obligations on states to protect and respect the rights of migrants within their jurisdiction, national entitlement policies are often at odds with these rights, since only weak mechanisms are available to hold states accountable for their human rights obligations.^{196,212,213}

In practice, the rights of irregular migrants are insufficiently protected.¹⁹⁵ This inadequate protection persists despite many existing legal norms that apply to the responsibility of states to protect and respect the human rights of vulnerable migrants.^{196,212,214} This situation partly reflects an absence of international guidance about how existing human rights norms should be applied to the situation of vulnerable irregular migrants. Additionally, it reflects the absence of a clear division of responsibility for protecting such migrants among international organisations.¹⁹⁶ Although the UN High Commissioner for Refugees (UNHCR) is mandated to safeguard the rights and wellbeing of refugees, no mechanism exists to enforce the application of and respect for international human rights norms by governments—rather, each state is able to interpret their relevance in national policy making.

Protection of irregular migrants on the political agenda

Increased attention by the media to the appalling living conditions and dangerous means of travel of irregular migrants has strengthened international concern about their human rights.¹⁹⁶ Civil and religious organisations, labour groups, and NGOs have become increasingly active on the issue. The International Federation of Red Cross and Red Crescent Societies is increasingly speaking out about the need to recognise and protect the rights of irregular migrants, and the Council of Europe in 2006 adopted a resolution on the human rights of irregular migrants.¹⁹⁶ The ILO Social Protection Floor Advisory Group has recommended that special efforts be made to reach irregular migrants.⁴⁵ The Global Commission on International Migration and the UNHCR have acknowledged the need to protect irregular migrants,²⁰⁸ and the UN Special Rapporteur on the Right to Health Anand Grover has presented a range of recommendations to the UN Human Rights Council aimed at ensuring that the right to health of all migrant workers, including irregular migrants, is respected, protected, and fulfilled.²¹⁵

Nevertheless, states have so far been reluctant to commit to new formal multilateral agreements to protect the rights of migrants. The only globally accepted protection framework for migrants that is explicit about irregular migrants (the 2003 UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families²¹⁶) has been ratified by only 47 countries; and no major migrant-receiving country has acknowledged the rights of irregular migrants specified in the convention.²⁰⁸ Rather than signing up to formal multilateral agreements, most migrant-receiving states prefer to develop cooperation on migration through informal regional consultative processes or through bilateral agreements.¹⁹⁶ This practice emphasises the challenges that sovereignty can pose to ensuring the protection of the rights and wellbeing of all people. As long as states do not come together to agree on guidelines

for applying existing legal norms to the situation of vulnerable migrants and clarify which international organisations are responsible for the implementation of such guidelines, irregular migrants are likely to continue to fall through the cracks in the system.¹⁹⁶

Global governance for health: key challenges identified

Migrants who cross borders in search of better lives often have no democratic representation, globally or nationally. They are disempowered with respect to the host country, which has the power to determine their legal status and their relative degree of social, economic, political, and legal exclusion from society. The difficulty in ensuring protection for the health and human rights of irregular cross-border migrants shows dysfunctions in the global governance system: mechanisms to hold states accountable for their obligations under international human rights and other conventions are weak; only nascent institutions exist to set standards for the treatment of migrants, especially irregular migrants; and institutions to ensure that health is taken into account in the development of migration policy are also weak.

Patterns of armed violence and effects on health

Changing patterns of violence

Throughout the world in the past 15–20 years, patterns of armed violence have been changing and expanding beyond the traditional features of organised armed conflict. Compared with the vast interstate wars of the 20th century, armed conflicts between large nation states are now relatively rare. Civil wars—those between a standing government and a rebel force—have fallen in number since a peak in the 1990s,^{5,217} although they often persist for many years and contribute to protracted refugee and internal displacement crises, and long-lasting border insecurities.

With the patterns of armed violence emerging in this century, the global governance regime must confront

intrastate instances of armed intergroup conflict, waged along communal, sectarian, or ideological lines, and often strengthened by drives to command territory and resources.^{5,217–219} Although these organised campaigns of armed violence have numerous causal roots, they often surface as vicious assaults on civilian populations, grave threats to the sovereignty of a state, and abrupt destabilisers of regional hopes for peace. Arguably, wars and armed conflicts more generally are one of the most powerful and enduring threats to human health and wellbeing.^{219,220}

Acute effects of armed conflict on civilian morbidity and mortality

Armed conflicts lead to civilian death, injury, disability, illness, and mental anguish.²²¹ Although data are woefully incomplete, estimates show that between 191 million and 231 million people died as a direct or indirect result of conflict during the 20th century.^{217,222} Civilian deaths have come to far outnumber combatant deaths, and this heavy preponderance arises from deliberate war strategies: direct targeting of civilians; gross inattention to principles of distinction, protection, and proportionality; and wanton destruction of health systems, basic societal functions, and infrastructure necessary to support civilian life and function.²²³

In the wars of the 21st century, data for civilian casualties continue to be sparse and incomplete. Still, major internal and international wars of the new century, such as those in Syria, Iraq, and Afghanistan, have claimed civilian lives estimated in the hundreds of thousands. In one of few systematic efforts to collect data for civilian deaths, the Oxford Research Group reported that the war in Syria killed 11 420 children younger than 17 years over a period of only 30 months.²²⁴ The deliberate targeting of health-care infrastructure and health professionals has been a recurring feature in Iraq and Syria, and the same tactic has been reported in the Democratic Republic of the Congo (panel 4). Hospitals in Iraq have been called killing fields;²³¹ in Syria, most hospitals in conflict zones have been severely damaged or abandoned, and many physicians, viewed as war targets, have been forced to flee the country.²³²

An inevitable result of the deliberate targeting of civilians is forced migration. When armed groups or armies attack specific neighbourhoods or communal groups, residents flee en masse and, dependent on geographical and security constraints, become either internally displaced or refugees in neighbouring countries. UNHCR estimates that by the end of 2011 there were 42.5 million refugees and internally displaced people worldwide, the highest cumulative total since 1994.²³³ The average length of protracted refugee situations is approaching 20 years (an increase from 9 years in 1993).²³⁴

Global governance and contemporary armed conflict

These terrible short-term consequences of present forms of armed violence challenge the capacity of the



Lydney Addario/VIII/Corbis

institutions of global governance to assess and respond. The post-World War 2 institutions and frameworks established to prevent and limit war tend to regard armed conflict as constrained in time and space, and tend to separate political and economic causes. Hence the responsible political and security institutions refer to bodies of law (the Geneva Conventions)²³⁵ and frameworks (the UN Charter chapters 6 and 7)⁵⁹ and attempt to act in short time horizons, whereas world economic institutions refer to trade and finance processes that operate on completely separate policy levels and across much slower deliberative timeframes.

However, the wars of the present century are more complex with respect to time and cause or provocation, and are less likely to be constrained by space, thanks to innovations in communications technologies such as the internet. The combination of political and socioeconomic exclusion, perceived and experienced by people as social injustice, serves to encourage acts of violence and supports larger-scale mobilisation of armed groups.

Grave and protracted violations of human rights lie at the root of these conflicts. Unjust treatment of specific groups on the basis of identifying characteristics such as race, ethnicity, religion, gender, class, caste, or ideology have all been identified as underlying causes of outbreaks of organised armed violence.^{5,236} Sudden shifts in favoured classes or groups, social exclusion of targeted groups, outright stigmatisation and persecution, forced evictions and territorial expulsions, and imprisonment or extrajudicial killing of opposition leaders or spokespeople have all been noted as precipitating trends or events.^{237,238}

Also evident, however, is that chronic economic deprivation, sudden economic perturbations, and pervasive criminality and corruption can aggravate or ignite underlying social tensions and precipitate armed conflict. The risk of conflict and violence in any society is, according to the World Bank's 2011 World Development Report,⁵ caused by a combination of exposure to both internal and external stress and the inability of legitimate institutions to cope with such stress. External stresses are those that emerge outside of a country's control and that therefore require global action. The OECD²³⁶ defines global factors that affect conflict as "licit and/or illicit processes operating at the international, regional, or cross-border levels and that influence a state's risk of fragility and conflict". The global food crisis in 2007–08 is an example of an external, economic stress factor; record-high food prices caused protests and violent rioting in 48 countries.²³⁹

Prevention of armed conflict has traditionally been viewed in political circles as a two-phase process: early prevention, when the social and political situation is fluid and unstable; and mitigation, when signs of organised armed violence have appeared and casualties are mounting. Both of these phases can go in and out of focus; successful interventions early on can postpone serious group violence; more thorough and sustained interventions might abate such outbreaks for years.²⁴⁰

Panel 4: Continuing conflict in the Democratic Republic of the Congo

Despite the official end of the war in the Democratic Republic of the Congo (DRC) in 2002, the internecine violence waged by many groups of armed non-state actors has continued unabated, with devastating effects on civilians. In the country's eastern regions, recurrent waves of attacks on villages and settlements—often located beyond the reach of health-care services—directly target civilians, including children and elderly people.^{225,226} The many lethal and non-lethal attacks on these civilians have included severe and widespread infliction of individual and gang rapes of women, girls, and boys,²²⁷ and people who have tried to flee have found it impossible to hide or to find safe areas.²²⁵

The conflict in eastern DRC has become increasingly criminalised, with warring parties vying for control of land and natural resources.²²⁸ DRC is rich in minerals, including reserves of wolframite (tungsten), diamonds, and gold. It also has supplies of coltan, which is used in mobile phones and other electronic devices, and cassiterite (tin), which is used in food packaging.

The misery of civilian deaths and the horror of sexual violence have caused international outrage. However, regional politics have so far prevented the creation of a stable ceasefire or a process of enduring demobilisation, disarmament, and reintegration. Thousands of Congolese national army troops, together with UN peacekeeping forces, have attempted to restore stability and safety in the region. However, these efforts have been unsuccessful. The formal armed forces remain inadequate to constrain the incessant attacks on civilians by several different rebel groups and outside armed forces.²²⁹ Humanitarian health assistance has been severely restricted by the conflict, and government services in the more contested regions have broken down.²³⁰

Priority must be given to ending the reign of armed violence in the region, which will require regional and wider international insistence on the rule of law and adherence to treaty obligations by those nation states implicated in the violence.

Global governance responses to new patterns of violence

The outstanding problem is one of integrated response, building on a more sophisticated and comprehensive understanding of the connections between escalating factors that increase the risk of outbreaks and intensification of armed violence. Some recent initiatives at the level of international treaties and trade agreements show a promising awareness of these connections. The 2013 Arms Trade Treaty offers an opportunity to reduce the potential for high levels of lethal violence.^{241–244} Global efforts to prevent the harmful effects of illegal trafficking have been developed, such as the Kimberley Process Certification Scheme for diamonds,²⁴⁵ the Extractive Industries Transparency Initiative,¹⁸² the Natural Resource Charter,²⁴⁶ and an initiative of the World Bank, FAO, and the UN Conference on Trade and Development (UNCTAD) on standards for international land purchases.⁵

These global initiatives are important for risk reduction and aim to promote necessary collaboration between rich and poor countries. But as social unrest in a state or region moves from early prevention phases into more acute crisis modes, the global governance systems for political and for economic engagement are still very separate. Only at times of high emergency do they converge, as in UN Security Council debates about the imposition of multilateral sanctions against an offending member state.

As a result, when the risk of armed conflict has escalated to an active crisis with heavy civilian casualties, the international community continues to look to coercive international mechanisms. These mechanisms include diplomatic or military efforts to require the nation state, if it still exists, to exert control over the fighting groups, or to impose on the state a range of coercive actions aimed at protecting civilians and bringing a cessation to hostilities. At this stage of violent disruption, positive economic interventions can become less relevant and the political force of collective diplomacy or armed action can prove necessary. The discipline of the Geneva Conventions and the threat of the International Criminal Court (ICC) loom large, and the previous constraints of various arms control treaties (eg, against landmines or chemical weapons) come into full play.

With the shift away from interstate war to patterns of violence less concerned with national boundaries, the challenge becomes increasingly about how to protect individuals rather than states. Progress has been made in the development of legal and normative frameworks to condemn attacks on civilians as unlawful in both peace and war—eg, UN conventions, the ICC, the UN framework on the Responsibility to Protect, and the Ottawa Treaty to ban landmines.^{227,247} Yet, even amid greater attention to civilian protection in arenas of global governance, substantial suffering has continued to occur in many armed conflicts around the world, such as in Syria.

Armed violence at the levels of criminal gangs and local militia is also on the rise.⁵ This small-scale but deadly violence does not fit into established legal or normative categories of war and peace. Criminal or political violence is estimated to affect 1·5 billion people worldwide, with disruptive effects on health and livelihoods.⁵

Global governance for health: key challenges identified

The fundamental issue is that societies at risk of armed conflict are those that are politically grossly unjust and perceived as socially and economically unfair. Several dysfunctions of global governance hinder the global community in its ability to effectively deal with this challenge.

First, no institutions have proven effective in guiding the international community in approaching the mix of volatile domestic factors (such as unemployment, income inequality, exclusion, and oppression) and the role of external disrupters (such as global economic instability, the international trade in small arms, and international organised crime) that might aggravate existing or rising internal tensions among groups and classes of people. These factors operate over a long timeframe, but several possible policy and treaty frameworks could be helpfully invoked at this phase of social, if not state, instability.

Second, multilateral institutions such as the UN have contributed to improved security and prosperity in many

parts of the world, and international humanitarian law has developed over the past 150 years to protect people from insecurity and violence and to govern the conduct of war and conflict. However, institutions are slow to adapt or interpret these mechanisms in view of new patterns of armed violence, which present several challenges to the post-World War 2 global order. For example, the UN Security Council, in its present political alignment, struggles to agree on interpretations of the language used in the UN Charter with respect to situations that permit deployment of UN forces to protect civilians in the face of active hostilities, and continues to rely on patchwork arrangements to staff and fund its peacekeeping deployments.²⁴⁸ The Geneva Conventions and the two additional protocols were designed to address wars between nation states; only through reliance on customary law and the potential broad reach of Common Article 3 can the precepts be applied to many subnational armed conflicts.^{217,249,250} Even if these measures create ample space for extended protection of civilians and expanded definitions of combatants in internal wars, the difficult question is an empirical one about how to discern in any given instance who is a combatant, who is a non-combatant, and who might be termed a terrorist. In this respect it is less the law itself than politics and resources that permit war and atrocities to continue in so many of the world's conflict zones.

Furthermore, global institutions remain largely reactive, although new understandings of the linked effects of political oppression and economic inequity have taken root at high levels in the UN, including within the offices of the Special Representative of the Secretary General for Genocide Prevention and Responsibility to Protect, as well as in the strategic conflict analysis of the UN Development Programme (UNDP).²⁵¹

The case of armed violence differs from the other six case studies presented in that plausible pathways through which transnational action and global governance affect health and health equity are especially difficult to trace. The root causes of conflict and violence are complex and multifaceted. The inability of the UN Security Council to take action in Syria, for example, speaks equally of this complexity as it provides evidence of power disparities between actors and the inflexibility of institutions.

Finally, global governance responses to conflict are often compartmentalised into issues of security, justice, and economic stresses, rather than being developed through a cross-sectoral approach whereby diplomatic, security, development, and humanitarian assessments and responses are integrated.⁵ To create a safer and more secure world for all, global inequity and injustice issues must be addressed with seamless continuity. The existing situation suggests an urgent need to establish mechanisms for regular meetings and discussions about what to do in specific parts of the world to prevent the eruption of armed conflict—mechanisms that bridge present institutional divides.

Furthermore, security, justice, and economic security⁵ are key determinants of stable and healthy societies. To create a safer and more secure world for all, issues of global inequity and injustice must be addressed. The Commission proposes that tackling the political determinants of health is an important step in this direction.

Barriers to global governance for health

Analyses across policy intervention areas

In the previous section we examined seven policy intervention areas and explored plausible pathways through which global political determinants affect health equity. In this section we look across the cases to show how competing norms and priorities can jeopardise achievements in global health, and identify five systemic dysfunctions that impede the realisation of global governance for health.

Power asymmetries and competing norms

The adverse health outcomes seen across the case examples, such as malnutrition, toxic waste poisoning, and injury and trauma caused by wars and conflict, could in many instances have been treated by health personnel in an adequate and functioning health system. But in many instances, these adverse health outcomes systematically affect the most vulnerable people—eg, poor people, those living in conflict situations, and those without adequate legal rights—who often have little or no access to decent health-care services. Furthermore, even with the best of health-care services available, the root causes of these avoidable health outcomes are far out of reach for the health sector to tackle alone. The unfairness in the distribution of health risks and health effects, as shown in the case examples, requires global, cross-sectoral policy interventions that reflect the value of human health and welfare.

The case examples show that health and wellbeing are in many instances subordinated to other societal objectives. For example, the case of the financial crisis and austerity shows how people's health and wellbeing are being compromised as a result of transnational economic policy making. Furthermore, contemporary global governance also allows the profit goals of private actors to displace health and social objectives—eg, the

way in which strong international investment treaties and trade rules override social policies, as seen in the case of tobacco and TRIPS.

Global norms, we have argued, limit the range of choice and constrain action, but also sometimes provide opportunities. Human rights law is one such opportunity.⁵⁵ But we have seen that the power of the market often supersedes the power of human rights norms, including the right to health. Also, governments in stable, resource-rich countries can prioritise other objectives over adherence to internationally agreed-upon human rights norms, as in the case of vulnerable irregular migrants. The Universal Declaration of Human Rights needs to be reinvigorated, and as a norm it could find mutual re-enforcement if combined with the surging public call for a more fair distribution of money, power, and resources than exists at present.

We have seen how power asymmetries challenge collective action across a wide range of global policy-making areas and effectively hinder the realisation of global governance for health. The norms, rules, and practices generated under these circumstances are not adequate to tackle health inequity. However, understanding how these global political determinants of health can arise requires a deeper investigation into where weaknesses in governance arrangements originate. Ultimately, whether global governance has beneficial or harmful effects depends on how it is practised.

Diagnosing systemic weaknesses

The power disparities that exist between different countries and other actors are an important cause of systemic dysfunctions in global governance. Actors that benefit from these power disparities shape how the rules of the game are written; and once written, the rules can be used to maintain such disparities. We have identified five such systemic dysfunctions (table). First, democratic deficit: participation and representation of some actors, such as civil society and health experts, in decision-making processes is insufficient. Second, weak accountability mechanisms: the means by which power can be constrained and made responsive to the people that it affects are weak and insufficiently supported by transparent governance processes.²⁵² Third, institutional stickiness: norms, rules, and

	Economic crisis and austerity	Access to knowledge and intellectual property	Investment agreements	Food security	Transnational corporations	Irregular migrants	Organised violence
Democratic deficit	..	✓	✓	✓	..	✓	..
Weak accountability	✓	..	✓	✓	✓	✓	..
Institutional stickiness	..	✓	✓	✓	✓
Missing institutions	✓	✓	..	✓	✓	✓	✓
Policy space for health	✓	✓	✓	..	✓	✓	✓

Table: Systemic dysfunctions that impede global governance for health

decision-making procedures are inflexible and difficult to reform (especially when they maintain entrenched interests), and thereby reinforce harmful health effects and inequities. Fourth, inadequate policy space across sectors: the means by which health can be protected both nationally and globally are inadequate, meaning that in global policy-making arenas outside of the health sector, health can be subordinated to other objectives, such as economic or security goals. Finally, missing or nascent institutions: international institutions (eg, treaties, funds, courts, and softer forms of regulation such as norms and guidelines) to protect and promote health are either totally or nearly absent.

Democratic deficit

As seen across the cases, global governance arrangements too often do not reflect basic democratic norms, such as equal rights of participation, fair representation, transparency, and accountability—a problem often called the democratic deficit. Beyond the nation state, we are far from anything resembling global democracy, since international decision-making processes do not operate on the principle of “one person, one vote”. Rather, the main principles are based on “one nation state, one vote” or, in some arenas and for the more powerful, “one nation state, many votes”. In the IMF and World Bank, the wealthiest countries have far greater influence over policy making than do less wealthy countries. They thus have greater ability to promote their interests and values through the international financial institutions than do less powerful countries, whose citizens are often the most likely to be directly affected by the policies that result. The democratic deficit is even greater outside of multilateral institutions. For example, in regional or bilateral negotiations over trade or investment agreements, no fixed rules exist for voting, participation, or transparency.

Non-state actors such as civil society organisations, marginalised groups, and health experts are also inadequately included in international decision-making processes. The potential for the engagement of non-state actors in global governance processes has been shown by progressive changes over the past 20 years. For example, civil society and a group of mostly small and medium-sized countries mobilised to make the Ottawa Treaty to ban landmines a reality. Furthermore, the Rome Statute in 1998 that led to the formation of the ICC as a permanent institution was the result of a group of 60 countries and a 700-member NGO coalition, which succeeded despite opposition from permanent members of the UN Security Council.²⁵³

Into the 21st century, the push for participation has gained further momentum, as shown by engagement from civil society and individual citizens through social media during intergovernmental meetings such as the World Health Assembly. At the UN, open online consultations have become increasingly common, such

as the World We Want process, which allowed individuals and civil society organisations to submit proposals linked to negotiations over the post-2015 development agenda, alongside states and multilateral organisations.

Dialogues and partnership arrangements with civil society and the private sector are expanding throughout the multilateral system. The ILO’s tripartite structure is one of the most inclusive within the UN system. The Committee on World Food Security enables meaningful participation by both states and non-state actors, and the WTO and UN Security Council have been under pressure to allow more participation by other state and non-state actors. The WTO allows civil society actors to attend ministerial meetings and regular briefings,²⁵⁴ and public access to official WTO documents has improved.²⁵⁵ Nevertheless, opportunities for civil society to influence the deliberation processes are generally poor and detached from the WTO’s regular policy-making processes.²³⁸ By comparison, industry can have more privileged access to national delegates, who can bring their proposals to the negotiating table.²⁵⁵

Despite progress towards more inclusive global governance processes, the democratic deficit remains a central feature of most global governance processes.

Weak accountability mechanisms and poor transparency

Accountability can be understood as “a means to constrain power and make it responsive to the people that it affects, especially people who tend otherwise to be marginalised and silenced”.²⁵² In the present global governance complex, consisting of a range of state and non-state actors, however, linking accountability directly to a single decision-making process or a specific actor is difficult. Accountability for the health effects of rules, norms, and policies that emanate from global governance processes can lie with a range of different actors, rather than with any one in isolation.²⁵²

At the transnational level, the means by which accountability can be ensured are weak. No single global political authority exists to hold states accountable when they violate or fail to comply with internationally agreed upon rules, norms, and standards, as was noted in the case of migration. Nor do adequate accountability mechanisms exist for non-state actors such as transnational firms that can move between jurisdictions with relative ease and are often more powerful and better resourced than the governments that should regulate them, as was seen with the example of Trafigura in Côte d’Ivoire. Furthermore, although the policies of international financial institutions, such as the European Central Bank and the IMF, can have substantial and widespread effects on health, as noted in the case of austerity in Greece, the lines of accountability between such institutions and the citizens they affect are tenuous at best.⁷⁹

Transparency is a widely recognised principle of good governance and a powerful method through which accountability can be strengthened. However, although

global governance actors ideally should answer to a global community of stakeholders,⁹⁷ some global institutions and governance processes do not operate with even a minimum level of transparency. For example, trade and investment agreements are still negotiated between governments behind closed doors. Similarly, adjudication of investment disputes between states and corporations is shrouded in secrecy, even when major questions of public interest (such as tobacco control legislation or drugs patents) are at stake.²⁵⁶ Opening up these processes to public scrutiny would improve the chances of public concerns—including health—being taken into account, and thereby strengthen their legitimacy. In environmental governance, civil society has been instrumental in creating pressure for increased accountability through transparency.²⁵⁷

Although broader participation and transparency in global governance can indeed enhance accountability, information is not enough when few means exist to then shape decision making. A means by which decisions can be challenged or issues remedied, traditionally done at the national level through courts, must therefore be central to accountability. In the examples discussed of violations of human rights norms by state and non-state actors, the exercise of international or extraterritorial jurisdiction by a court has been a noted feature of efforts to strengthen accountability. However, although important cases have been tried, such jurisdiction is little used. For example, during its first 10 years of existence, the ICC heard only ten cases and convicted only one person.²⁵⁸

In the contemporary governance complex, we still do not have adequate means to ensure the accountability of states and non-state actors for the health consequences of their actions.

Institutional stickiness

The ability of international institutions to adapt to changing environments while remaining resilient against opportunistic reforms by actors seeking undue influence is crucial for institutions to remain legitimate and effective. However, once international institutions are created, power can also become entrenched, and those with power will often resist surrendering it. This institutional stickiness makes it difficult to reform institutions to evolve with the times, and means that those disadvantaged by established rules will face daunting challenges when seeking to change them.

As discussed in the case of violent conflict, many institutions of global governance—built for the immediate post-World War 2 world—have come under scrutiny as being “outdated and anachronistic”, having undergone “almost no formal institutional reform to make them more relevant to the 21st century”.⁹⁷ The anachronistic structure of the UN Security Council, with the victors of the second world war retaining permanent seats, and agreements such as TRIPS and the Agreement on Agriculture that cannot be amended except with full consensus of all WTO members are examples of sticky

institutions that create a strong bias in favour of the status quo. A range of other examples also exist, such as the difficulties in reforming the UN Economic and Social Council²⁵³ and the reluctance to open the governance of WHO to a wider range of stakeholders.

Institutional structures that favour powerful actors thus almost preclude reform, since little incentive exists for such actors to allow a change in the rules if to do so means ceding power. As a result, rules are biased in favour of the status quo and interests become entrenched. However, such entrenchment does not mean that reform is impossible. The UN Human Rights Commission, criticised for allowing member states with very poor rights records to block resolutions, was restructured into the UN Human Rights Council. Although this change did not address many underlying weaknesses of the UN architecture on human rights, it did make a member state’s record on human rights an important factor for gaining a seat on the Council, which is an important step forward.

Institutional stickiness can drive some actors to seek alternative strategies or to create new institutions entirely. A tendency in the new millennium has been a growing pluralism of governance, with countries turning, for example, to regional arenas, new groupings based on common interests, multipartner initiatives, and voluntary standards.⁹⁷ Similarly, the BRICS countries recently announced that they aim to establish a new development bank, signalling a dissatisfaction with the governance of existing multilateral banks.²⁵⁹

Although institutional stickiness can be addressed, it remains a major impediment to reform of existing institutions to better protect and promote health.

Inadequate policy space for health

International rule making has proliferated, with the number of international bodies, conferences, and multilateral treaties growing from about 2900 in 1981 to 4900 in 2003. This trend has produced a system of overlapping, conflicting, and nested sets of rules (sometimes called regime complexity),²⁶⁰ which can blur obligations and responsibilities, and complicate accountability. Although the fact that health is affected by decision making outside of the health sector is increasingly recognised, adequate policy space for health has not yet been ensured within other sectors.

Although some global standards, such as the FCTC and treaties that govern trade in toxins, can increase government policy space for the protection of health, other global standards can reduce this policy space. A major weakness of the system is that health concerns are too often subordinated to other objectives, such as economic growth or national security. The struggle to carve out policy space for health is clearly shown by the example of investment rules tying the hands of governments’ attempts to regulate tobacco. Even existing policy space is threatened, as actors seek new rules that



Lawrence Manning/Corbis

were beyond reach in multilateral arenas, such as TRIPS-plus provisions in regional trade agreements that limit the safeguards contained in TRIPS.

States can, however, also preserve policy space for health by renegotiating, withdrawing from, or refusing to sign up to international rules that will undermine public health. Policy space can also be protected through special provisions to protect health, such as ring-fencing of social spending in response to financial crises, or creation of health exceptions in trade and investment treaties for tobacco control, drugs, and food. Finally, policy space can be carved out when global rules are implemented at the national level.

National policy-making processes, such as negotiations between ministries of health and trade, can be as important as global processes for the protection of policy space for health across sectors. The Health in All Policies²⁶¹ approach builds on what health ministries can do to advocate for health across government ministries at the national level. However, making this approach operational and effective at the level of global governance is more difficult. For example, WHO has so far not been able to open up space and arenas for policy dialogue inclusive of other relevant intergovernmental organisations, governments, and non-state actors. The intergovernmental membership, represented by the health ministries, prevents sufficient engagement with a broader set of actors to address complex challenges such as the social determinants of health, the growing challenges of non-communicable diseases, and the health security threats of pandemics, climate change, violence, and humanitarian crises. This situation has limited the effectiveness of WHO, making it unable to coordinate a coherent approach that unites political and public will and private sector readiness to act on necessary policies and regulations.

Weak institutions to protect health in other sectors—especially politically powerful sectors such as trade and security—thus remain a major weakness of the global governance system, and such weakness must be addressed both globally and nationally.

Missing or nascent institutions

Despite the proliferation of global rule making, important health issues still exist for which transnational institutions are missing, or at best nascent. For example, institutions to govern transnational non-state actors or issues (eg, armed groups, illegal trafficking networks, transnational corporations, or volatile markets) often either do not exist or are inadequate for the task. Economic globalisation has outpaced political globalisation—ie, the development of institutions that could govern the global market effectively and protect societies against market failures. As seen in the case of food security, speculation in food commodity markets led to food price volatility, and the absence of effective institutions to prevent or counteract this problem created food insecurity for already vulnerable populations. Further examples of under-regulated transnational

markets include financial markets, the arms trade, human trafficking, marketing of unhealthy foods, and cross-border dumping of toxic waste.

Sometimes norms or rules can be agreed upon, but mechanisms for enforcement remain weak. For example, migration of health workers from poor to rich countries is governed by the non-binding WHO Global Code of Practice on the International Recruitment of Health Personnel, but this system does not have enforcement mechanisms. In other cases, regulations remain incomplete. Despite recent progress on regulation of trade in harmful chemicals, exemplified by the 2013 Minamata Convention on Mercury,¹⁹⁰ only 22 of thousands of potentially harmful chemicals are subject to international treaties that govern cross-border movements. Some advocates have called for a comprehensive global chemicals regime to supersede the existing piecemeal approach.²⁶² Additionally, as noted in the case of migration, governments have been reluctant to articulate specific international norms for the protection of irregular migrants.

Some issues are subject to fragmented systems of regulations that do not have clear authority. For example, no single authority has the responsibility or capacity to address food security. Rather, food security currently depends on a multitude of interlinked, and sometimes conflicting, transnational norms and rules. Despite important initiatives such as the UN high-level task force on global food security, individual decisions by governments, consumers, industry, and investors that can affect global food supply remain largely uncoordinated and unregulated.

Overall, nascent transnational institutions to protect health, such as voluntary standards, must be strengthened and new institutions and regulations could be needed when the operations and interests of some actors seriously conflict with people's health and wellbeing.

Tackling political determinants of health Harnessing the power of norms, knowledge, and responsive institutions

The existing structures and processes of global governance are fragmented and unfit to handle the broad cross-sectoral and interconnected challenges that prevent effective global governance for health. Furthermore, they do not adequately mitigate the major power disparities that continue to characterise global politics and undermine efforts to ensure health equity. Power imbalances will remain a central feature of global governance, but more open and equitable processes for the generation and dissemination of knowledge would allow the status quo to be challenged.

Transformational change is needed in the way in which policies and global decisions that affect health are made, and in the norms that inform them. A new, interconnected global agenda for sustainable development will require a more democratic distribution of political and economic power and a transformed global governance architecture,

able to overcome the barriers created by organisational turf wars, fragmented action, and narrowly conceived national interests that currently put both the global environment and human health at risk.

We have argued that sources of health inequity are cross-sectoral in nature and demand cross-sectoral responses. Therefore, we call upon governments, which as members of international organisations and platforms in all sectors (ie, WHO, WTO, IMF, the World Bank, FAO, the Committee on World Food Security, ILO, UNHCR, UNDP, UNCTAD, and the UN Human Rights Council) have the capacity to initiate a cross-sectoral agenda for change to achieve sustainable health and wellbeing for all. The support for such an agenda must be sought among non-state actors—civil society, philanthropic organisations, the media, business, and academia.

Agenda for change: convening, informing, and monitoring

Any proposal for reforming or creating new global institutions is likely to face the same barriers and dysfunctions that have been identified in this report, such as power asymmetry, democratic deficit, and institutional stickiness. The voices of the people and the imperative of the cause must ultimately be what drive change and hold national and global leaders accountable. Healthy people are as important as a healthy planet, and steps must be taken to overcome the most important limitations of absent or nascent institutions, weak accountability, and inadequate policy space. This process will require agents of change and readiness for change, both within the UN, among the political leaders of the world, within social movements, and in the private sector.

The Commission offers two proposals to fill existing gaps in the institutional framework of global governance for health, which could be within reach as an agenda for change and should be further explored: a UN Multistakeholder Platform on Global Governance for Health and an Independent Scientific Monitoring Panel on Global Social and Political Determinants of Health. These proposals could also be extended to include mandatory health equity impact assessments for all global institutions and strengthened sanctions against non-state actors for rights violations. As an immediate action, governments and the UN Human Rights Council could strengthen the roles of existing human rights instruments for health. These proposals should be viewed within the broader context of, and as a contribution to, global discussions about how to strengthen global governance for sustainable development.

A UN Multistakeholder Platform on Global Governance for Health

Policies, regulations, and actions with major implications for health are now compartmentalised across various institutions and processes in the global

governance system, with insufficient attention paid to the ways in which they are interconnected and interact. To enable global policies for health and sustainable wellbeing, the Commission proposes that a Multistakeholder Platform on Global Governance for Health should be considered. Drawing lessons from the FAO's Committee on Food Security, such a platform would engage governments, intergovernmental organisations (in the areas of finance, trade, labour, food, environment, human rights, migration, and peace and security), and non-state actors including civil society, academic experts, and business. This approach is largely compatible with the proposals by the UN Secretary General on fostering renewed global partnerships.⁵⁸

The Platform (figure) should derive its legitimacy from the UN and serve as a policy forum (not a funding platform) that provides space for diverse stakeholders to frame issues, set agendas, examine and debate policies in the making that would have an effect on health and health equity, and identify barriers and propose solutions for concrete policy processes. It will share and review information, influence norms and opinions, and shape action by making recommendations to the decision-making bodies of participating state, intergovernmental, market, and civil society actors. In so doing, the Platform can respond to the challenge of weak accountability mechanisms at the global level by creating a public arena in which actors are expected to be answerable for the health consequences of their actions. The Platform will represent an opportunity to respond to what we have described as institutional stickiness. Its recommendations should be fully transparent, with open access to all information about the policy forum deliberations and their inputs and outcomes, including specific policy advice presented to

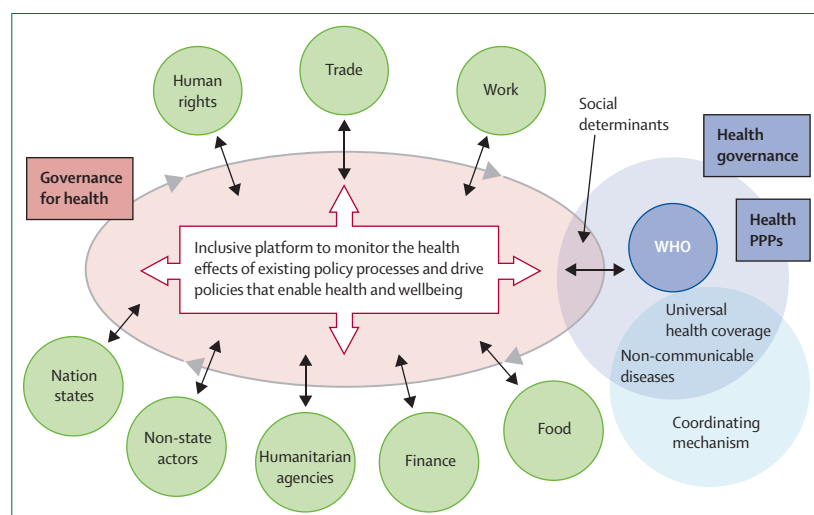


Figure: UN Multistakeholder Platform
PPPs=public-private partnerships.

the participating stakeholders and their governance bodies. The complexity of this idea necessarily requires a consultative process with key institutions, governments, and all other stakeholders, clarifying the Platform's terms of reference, leadership, and the location of a secretariat (panel 5).

The process to shape the post-2015 development agenda is expected to underline the need for review and reform of the architecture of global multilateral institutions, aiming towards a more interconnected, inclusive, and simplified system of global governance. Governance for health and sustainable wellbeing will require such reforms, and the proposed UN Multistakeholder Platform would represent a step in this direction, enabling more inclusive, better integrated, and more coherent policy dialogue across institutions and arenas.

The Platform would be independent of the regular health governance processes of WHO and its partners in the health architecture (such as the public-private partnerships for health), but would include WHO in its membership and benefit from the normative guidance and leadership that WHO can provide as the UN agency responsible for health. The Platform would take on policy dialogue that involves issues and actors far beyond the health sector, and thereby complement and strengthen the ability of WHO to serve in its mandated function in global health governance. Such an approach would lend support to WHO in its work on multidisciplinary policy responses to non-communicable diseases and add strength to promotion of the universal health coverage agenda and initiatives to address the social determinants of health.

An Independent Scientific Monitoring Panel on Global Social and Political Determinants of Health

The Commission also proposes the establishment of an Independent Scientific Monitoring Panel on Global Social and Political Determinants of Health, to be

grounded in a network of academic institutions and centres of excellence across all world regions. The Panel will deploy the best minds to investigate the complex interaction of forces that lead to health outcomes, the risk factors for adverse health outcomes, and the varying effectiveness of different global governance arrangements for enabling and protecting health. Competing or conflicting interests among stakeholders and continuing debates about methods for analysis make the case for an independent global monitoring mechanism. The Panel will call for, receive, assess, analyse, debate, and communicate multiple lines of independent evidence—across disciplines—and provide independent and transparent strategic information to the UN and other actors that affect global governance for health.

The Panel should make full use of right-to-information policies so that its monitoring activities can inform decisions before they are made, as well as tracking the effects of such decisions. Data need to be generated that complement existing systems of information about biomedical outcomes and health systems, focusing also on a political analysis of the social and political determinants of health. To challenge the status quo, strengthen and broaden our evidence base, and address some of the power disparities that characterise the present system of knowledge production, the Panel should recognise diverse sources and types of knowledge, and invest in building research capacity among people whose health is most directly affected by the global social and political determinants of health.

This type of research will raise additional challenges, both in terms of defining indicators and ensuring independence. The main challenge will be to follow the health effects of political determinants across sectors—eg, the effects of human rights abuses in conflict and those of trade agreements. The first task for the Panel should be to propose a monitoring framework that is able to track progress in overcoming the social and political determinants of adverse health outcomes.

Analogous institutions have already been created, such as the Intergovernmental Panel on Climate Change and the newly established Intergovernmental Platform on Biodiversity and Ecosystem Services, to assess the latest research into the state of the planet's fragile ecosystems. The health of people, broadly conceived in terms of wellbeing and not just absence of disease, merits equal attention.

Several options should be explored for the establishment of the Independent Scientific Monitoring Panel on Global Social and Political determinants of Health. The basis needs to be a UN mandate and a scientific, independent role. It could be created by governments or by non-state actors such as academic institutions, and should have a strong contribution from civil society. Situating the Panel in initiatives established by universities themselves, such as global consortia or associations of academic institutions or knowledge centres, could be an attractive option.

Panel 5: Issues to be worked out in establishing the UN Multistakeholder Platform

Some of the issues that would have to be worked out in a broad and open consultative process include:

- Formal connection to the UN and participating intergovernmental agencies
- Location of a small secretariat in an accessible and affordable location
- Ways to link to established mechanisms for inclusive participation in the engaged intergovernmental agencies, as well as to social movements and popular struggles against institutions and corporations that violate the right to health
- Representation of major groups of non-state actors, governments, and regional groups, with rotating membership and special opportunities for low-income countries and other weak or disadvantaged stakeholders

Health equity impact assessments

As more independent, evidence-based research into the social and political determinants of health is being fed into the global governance system, international institutions could be mandated to do health equity impact assessments of all their policies and practices. Such assessments could call attention to health threats, provide much-needed evidence to decision makers, and change views on policy, especially when combined with political mobilisation.²⁶³ For example, the IMF, World Bank, WTO, WHO, and the UN Department for Peacekeeping Operations could all be required to assess their advice and policies with respect to their effects on the social determinants of health, drawing on coordination and advice from the Independent Scientific Monitoring Panel and the UN Multistakeholder Platform.

In line with this proposal, the report of the UN high-level panel on the post-2015 development agenda,²⁶⁴ in discussing corporate social responsibility, notes that many companies recognise “that if they are to be trusted partners of governments and civil society organisations, they need to strengthen their own governance mechanisms and adopt ‘integrated reporting’, on their social and environmental impact as well as financial performance”. This commitment could be extended to assessments of the effects of policies on health and health equity.

Strengthening existing mechanisms

Proposals for immediate action

Changing the processes and practices of global governance into a system that better harnesses the global political determinants of health will take time. We therefore also propose some immediate actions that are intended, not to root out the very causes of persistent health inequities, but to remedy the effects of the inequitable distribution of health through improved sanctions and security.

Strengthen the use of human rights instruments for health

The report of the UN Secretary General, *A life of dignity for all*,⁵⁸ highlights the growing emphasis on a rights-based agenda for sustainable development, noting that “people across the world are demanding more responsive governments and better governance based on rights”. The Commission underlines the importance of building on this momentum.

Although the human rights system has important mechanisms in place to drive an agenda of this type, the application of human rights instruments for health, including access to drugs, sexual and reproductive rights, and violence against women, has been controversial and therefore underused. The opportunity should now be taken to seek improved recognition of health as a human right, integrated with other social, economic, political, and civil rights in the agenda of global governance. Calling attention to violations of agreed human rights standards by state and non-state actors is crucial.

The mandate, reports, and recommendations of the Special Rapporteur on the Right to Health can be better used to inform policies and strategies that affect health, including by having the Special Rapporteur report to the World Health Assembly. Governments and other actors should work to strengthen links between the existing international human rights system to make better use of existing surveillance capacities, with reports and guidance taken into account in multilateral arenas such as the IMF, the UN Security Council, WHO, the World Intellectual Property Organization, WTO, and the World Bank. Governments on the UN Human Rights Council should expand the mandates for the Special Rapporteurs to include human rights audit of the decision-making processes of international organisations. This issue of expanded mandates is relevant to all policy areas discussed in this report, and could be important for both of the proposed institutions—ie, the UN Multistakeholder Platform and the Independent Scientific Monitoring Panel.

Strengthen mechanisms for sanctions

To strengthen weak accountability at the transnational level, stronger mechanisms for sanctions are needed. Sanctions can lead to punishment of those actors who violate agreed-upon standards, or to remedy for harms committed, whether in the form of an apology, commitment not to repeat, policy changes, or reparations.

Although national courts can play an important part in sanctioning violations,²⁶⁴ when they are unable or unwilling to try specific cases, international courts might be needed. In view of the many global power imbalances that can limit the effectiveness of national courts, the international judicial system is an important backstop to national systems and could offer a useful mechanism for strengthened transnational accountability. The state-based international judicial system should, however, be strengthened to encompass a broader range of non-state actors and to enforce sanctions against a broader range of violations.

The existing patchwork of international courts has wide gaps, especially for cases in which non-state actors are potential plaintiffs or defendants. For example, the ICC does not accept cases brought by non-state actors such as minority groups or civil society organisations, and transnational corporations cannot be brought before the ICC, since its mandate is restricted to prosecuting human beings. Furthermore, the ICC covers only a short list of violations. An expansion of eligible violations could involve standards directly related to the social determinants of health, such as environmental pollution, corruption, abuse of labour rights, and collusion in gross human rights violations. Recognising the many challenges involved in broadening the formal mandate of the ICC, we suggest as a first step the creation of a regularly scheduled forum at which civil society organisations could present reports on alleged violations requiring greater attention from the court.



Strengthen and transform mechanisms for global solidarity and shared responsibility

Global governance for health must be rooted in commitments to global solidarity and shared responsibility, building on national and international commitments to work together to ensure fulfilment of the right to health. Such commitments include contributing a fair share to development assistance for health, based on ability to pay, through both traditional and innovative means. This vision and commitment, spearheaded by the African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria,²⁶⁵ has been offered by the AIDS movement as a contribution to the intergovernmental dialogue on the post-2015 global development agenda, and should be further explored.

Power asymmetries and the unpredictability in the present OECD-based bilateral and multilateral regimes of international development assistance need particular attention. The Commission believes that there is an urgent need for a framework for international financing that is broader than what is currently defined as official development assistance to ensure the financing of a more universal agenda for socially sustainable development. We also note the need for further attention to binding instruments and compulsory, assessed contributions from all states according to ability to pay, as proposed by the Special Rapporteur on the Right to Health, Anand Grover.⁸⁹ In this context, the financing of health-related global public goods also requires renewed attention.

Strengthened and transformed mechanisms for global solidarity and shared responsibility based in financing models beyond traditional development assistance are highly relevant and need priority attention. Examples include health research that meets the needs of poor people and mechanisms for global social protection transfers.

Proposals have been tabled by many actors, including the WHO Consultative Expert Working Group on Research and Development,¹¹⁸ to ensure sufficient investment in health-related research and development in areas for which market incentives are insufficient.²⁶⁶ One of the options is a treaty under which countries would commit to finance research and development in accordance with their ability to pay, while the research would be oriented towards the most important global public health needs. This proposal would have the effect of mandatory financial transfers—albeit indirect—from wealthy countries to poorer countries (which would benefit most from the research). If a binding treaty is not politically feasible, an alternative model could be the non-binding assessed contribution scheme used for the replenishments of the International Development Association (the arm of the World Bank that provides grants and soft loans to low-income countries), contributions to which are roughly proportional to a country's share of the global economy.

Universal health coverage is about “solidarity between the healthy and the sick and between population groups in all income classes”.²⁶⁷ Just as social health insurance schemes and risk pooling for medical expenditure are central to universal health coverage, social protection is key to the whole social dimension of sustainable development. Good reasons might exist for applying these principles beyond state borders. Global social protection would entail appropriate distribution of national and international responsibilities, with mechanisms to collect and redistribute transfers that are both duty-based and rights-based. Whether a single global social health protection fund⁹² would be better than the present patchwork of thousands of bilateral and multilateral global social protection transfers remains a controversial issue, but these are important questions that need to be further explored and debated.

Conclusion

The overarching message of the Commission on Global Governance for Health is that grave health inequity is morally unacceptable, and ensuring that transnational activity does not hinder people from attaining their full health potential is a global political responsibility. The deep causes of health inequity are not of a technical character, devoid of conflicting interests and power asymmetries, but tied to fairness and justice rather than biological variance. Health equity should be a cross-sectoral political concern, since the health sector cannot address these challenges alone. A particular responsibility rests with national governments. We urge policy makers across all sectors, as well as international organisations and civil society, to recognise how global political determinants affect health inequities, and to launch a global public debate about how they can be addressed. Health is a precondition, outcome, and indicator of a sustainable society, and should be adopted as a universal value and a shared social and political objective for all.

Contributors

OPO was chair and JD was cochair of the Commission. CB, PB, VC, JF, SF-P, BPG, RG, JG, JL, MM, DM, GIM, NM, SM, AN, and GO were members of the Commission. EB, ALL, SM, SR, KIS, and IBS were the main members of the research team. All members of the Commission contributed to the ideas and recommendations, and to the structure of the report. They also actively participated in writing, editing, and commenting on drafts developed by the research team. All authors approved the final submitted version of the report.

Conflicts of interest

We declare that we have no conflicts of interest.

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