The Role of Economic Power in Influencing the Development of Global Health Governance

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The configuration of economic actors has shifted dramatically in recent decades as a consequence of the shift from an international to global economy. The 21st century thus faces a fundamentally different economic landscape, with governance far less about formal nation-state negotiation, and far more about informal mechanisms of state and non-state negotiation. Although economic power has always played a role in defining international health governance, this changing global economic context has increased the role of economic power in the development of global health governance. To ensure the continued protection and enhancement of global health, it is imperative for the health profession to recognize and more actively engage with this changing economic context, in order to seize opportunities and minimize risks to global health. If it does not, the danger is that global health governance will increasingly be determined by economic organizations with the principle concern not of health but of market liberalisation, ultimately constraining the capacity of nation-states to undertake measures to protect and enhance the health of their populations.

INTRODUCTION

The process of governance entails the establishment of institutions, legislation, rules, norms, principles, and decision-making procedures to structure those actions and means adopted by societies to promote collective action and deliver collective solutions in the pursuit of common goals.[1] Although the relative "power" relations of the actors involved influences this process, defining power is complex and context specific.[2] For instance, Lukes defines power generally as the ability to: (a) make decisions due to material capabilities (i.e. force someone to do something they would otherwise not do); (b) set the decision making agenda; and (c) shape the preferences of others so that they consent to decisions.[3] Barnett and Duvall take this further, and seek to classify power as comprising four dimensions.[4]

- Compulsory power, which covers forms of interaction that allow one actor to have direct control over another and, at the extreme, force them to do something they would not otherwise do. An obvious example of this is *military* power.
- Institutional power, which covers the more indirect control of one actor over another through the design of (international) institutions that work in their favour at the expense of others. This would encompass *political* power.
- Structural power, which concerns the overall constitution of actor roles, such as the designation within the capitalist world-economy of social positions for capital and labour. This framework for structuring actors thus confers differential abilities to alter their circumstances and

fortunes. This would be consistent with a form of *ideological* power (viz. socialist systems as alternatives to capitalism).

- Productive power, which concerns the extent to which one actor is able to exert control over another through the possession, use and distribution of resources and assets. This is consistent with *economic* power, where those with more "productive power" have greater freedom to exploit others in order to generate some form of market distortion to their own benefit.[5]

Historically, key aspects of power – be they political, ideological, military, or economic – are focused within the nation-state. The nation-state has been the key actor with respect to both internal governance and also *international* governance. Globalization has challenged this pre-eminence of the nation-state, increasing the presence and role of non-nation-state actors in *global* governance.[6] That is, the evolution from the international economy – where states are the key actors – to a global economy – which encompasses state and non-state actors – has correspondingly changed the landscape of governance from one of international governance to one of global governance.[7] The core feature of this seemingly semantic change has been the disjuncture that is generated between economic power and other forms of power. It is no longer the case that all forms of power are mostly concentrated within a nation state. Although military power, and to a large extent political and ideological power remain state based, economic power is increasingly less so. And as economic power becomes increasingly decoupled from the nation-state, so too has political and ideological power; economic power is therefore critical in the development of 21st century global governance.

A key component of globalization is a process of closer integration of economies, which has influenced, and been influenced by, ideological hegemony and the distribution of wealth between states, individuals, and institutions. This has extended the reach and influence of non-state actors, and has led to the development of international institutions concerned with economic development.[8] Further, globalisation has blurred dividing lines between state sectors (the era of "joined up government") and states themselves, such as through the sourcing of components from a large number of companies to assemble automobiles, computers, and cell-phones.

For instance, between 1970 and 2000 the number of trans-national corporations (TNCs) grew from some 7,000 to 55,000, with the revenues of the largest 200 TNCs amounting to more than that of 182 of the world's nations, or 80 percent of the world's population.[9] One repercussion of this has been the spread of production over numerous countries, with an increasing network of component production in different countries and assembly in another. The same is now occurring in financial services, where from 2003 to 2006 the number of financial institutions having offshore operations increased from 10 percent to 75 percent, with a corresponding increase in the average number of staff employed in these offshore operations by 1,800 percent, and the number of countries hosting offshore activities rising from five to 22.[10] This process reduces the power of individual states and increases the power of the company as it is less vulnerable to disruption by nation-state issues, giving it greater power in the global economy (the ability to take an attacking stance and threaten movement out of a country,

and defensive ability to be little affected by threats of sanctions against them).[11]

The supposition in this paper is that, increasingly, with the growth in international trade and finance, international institutions focused upon economic development and state policies that affect international trade, such as monetary and fiscal policy, have gathered momentum in determining global power relationships, and hence global governance. Although economic interests have always played a key role in defining *international* health governance, such as the International Sanitary Conferences, the configuration of economic actors, however, has shifted dramatically in recent decades as a consequence of globalization and the shift from an international to global economy.[12] The 21st century thus faces a fundamentally different economic landscape from previous centuries. The implication of these shifts in economic power is the declining capacity of national governments to regulate within a global economy given the increasing trans-nationalisation of economic power. With respect to health, the implication is that global health governance will increasingly be determined by economic institutions with the principle concern not of health but of market liberalisation, ultimately constraining the capacity of nation-states to undertake measures to protect and enhance the health of their populations.

As global health governance becomes far less about formal nation-state negotiation, and far more about informal mechanisms of state and non-state negotiation, economic power has grown in influence.[13] Fidler characterises this change as moving to a system of "open-source anarchy," where governance space is accessible by states *and non-state* actors, presenting a challenge to the "old school anarchy" of governance controlled strictly by nation-states, rendering nation-state governance initiatives vulnerable.[14] In this sense, Fidler distinguishes between governance as "software" and as "hardware," where software refers to the norms and structures behind the protection and promotion of global health, and hardware refers to the physical infrastructure used to enact the software, and thus current national and international institutions. As institutions tend to remain the purview of nation-states (themselves or through international institutions), "open-source anarchy" is a constant stress on governmental capabilities and is the avenue by which economic power has become more prominent.

This paper therefore provides an overview of the contemporary landscape of global health governance, looking especially at the key institutions involved in global (health) governance (the nation-state, regional trading bodies, inter-governmental bodies, private commercial sector, and private non-commercial sector) and the implications for global (health) governance from changes in the balance of economic power within and between them.

NATIONAL GOVERNMENTS

Health is commonly seen to be a responsibility of national government. In all systems there is a significant role for national government in health, even in cases where there is little role in other areas. This role encompasses monitoring and protection from infectious disease outbreaks, securing clean water and safe food, through to, in many countries, involvement in the finance and/or provision of health services directly to (groups of) the population.

Health, and health care especially, may thus be thought to be governed by national government, especially by those within the health sector. However, the greater level of private involvement in health – indirectly and directly – by non-state actors leads to a diminishing authority and capacity of national governments to influence health determinants and outcomes.[15]

For example, developments in the pattern of ownership and production have meant that national regulations are increasingly insufficient to control the arms trade. Weapons are now commonly assembled from components sourced from across the globe, with offshore production facilities, foreign subsidiaries, and other collaborative ventures, sometimes in countries that have few controls over where the weapons go, or to what ends they are used.[16]

REGIONAL TRADING BODIES

Regional trading bodies developed as an attempt to protect a group of nations from the rising power of others, securing greater economic power through greater numbers acting together. This serves both within the body in terms of preferential and/or equal trading arrangements for members, and without the body in negotiating with other powerful players – states or otherwise. These bodies thus, rather paradoxically, serve to both bolster national governance, through providing some element of protection and greater negotiating power with those outside the body, but simultaneously also erode national governance through overriding national legislation.

For example, regional treaties may constrain the range of policy options available to a national government to control alcohol availability, such as minimum legal purchasing age, government monopoly of retail sales, restrictions on hours or days of sale, outlet density restrictions, and alcohol taxes.[17] In Finland, for instance, the national alcohol monopoly was weakened after joining the European Union (EU) and becoming subject to the European Free Trade Agreement in 1994. Similarly, the European Court of Justice recently ruled that Sweden's law limiting alcohol advertising, passed in 1979, was an obstacle to the free flow of goods and services and that it affected foreign alcohol products more adversely than more familiar domestic products. European trade agreements have also been used to challenge the levels of Norwegian taxes on wine and Danish excise duties on spirits.

There is also the irony of stricter environmental protection in the EU contributing to the build up of hazardous wastes in the Third World, where laws to protect workers and the environment are inadequate or not enforced. For instance, the export of hazardous wastes from the countries of the Organization for Economic Cooperation and Development (OECD) to less developed nations grew from some 4 million tons of hazardous wastes in 1989 to more than 1,000 million tons by 1993. Unfortunately, many of those countries importing this waste have neither the technical expertise nor adequate facilities for safely recycling or disposal, with many employees at these facilities developing a variety of health problems.[18]

INTER-GOVERNMENTAL BODIES

Inter-governmental bodies have been a significant development in the post-war period. Some of these bodies were developed to promote post-war reconstruction and economic development, such as the World Bank (WB),

International Monetary Fund (IMF), and World Trade Organization (WTO). Others were developed with a focus on promoting peace and security, such as the United Nations (UN) Security Council and the North Atlantic Treaty Organization (NATO), and others given more specific functional tasks, such as the World Health Organization (WHO), Food and Agriculture Organization (FAO), and International Air Transport Association (IATA). However, over time many non-health focused institutions have come to influence health governance.

Although the WHO is the principal international organisation with a broad health governance remit, it has historically focused on disease areas, and provided narrow support for health systems in specific countries, rather than on interaction with international and global economic actors.[19] However, the case of Severe Acute Respiratory Syndrome (SARS) could well prove to be a watershed in this respect. WHO stepped to the forefront of the response to the SARS outbreak, acting quickly in supporting the identification of the virus and its properties, as well as coordinating travel advisories and other control measures and being the health community's voice on this issue to the media and policymakers. It was, of course, not without its critics in this respect, particularly those, such as Canada, who bore the brunt of the impact of some of the control measures. In this respect, the ability of WHO to impact upon not only a national health system, but more widely on a national economy – and more especially to carry the authority to do that – was a significant step in its role in global health governance.[20]

Nonetheless, although it was able to use some of the lessons from SARS in the revision to the International Health Regulations (IHR), and plans for responses to other public health emergencies of international concern, it remains to be seen whether it continues to assert this "power." For instance, WHO has "observer" status at the WTO. This means that it is unable to represent Member States when health concerns are debated, or to voice an opinion independently. It may, of course, offer advice and support more informally outside the formal negotiation, but its abilities to intervene in areas of negotiation which are directly relevant to health and health systems seriously constrains its abilities as a leader on global health governance.[21]

In terms of non-health focused institutions, the IMF and WB in particular have come to have significant impacts upon health and health governance. The IMF especially was to be a guardian of international fiscal stability; particularly keeping a cap on inflation. This has been achieved through pressuring (mostly developing) countries to limit public spending, including their health budgets. The "austerity measures" linked to Structural Adjustment Programmes (SAPs) and Poverty Reduction Strategy Papers (PRSPs) have been a key instrument in reducing many national health expenditures and thereby the provision of state-based health services.[22] The WB too has become a significant actor in global health governance in recent decades, although more directly than the IMF through the funding of health projects, especially related to HIV/AIDS. However, the WB has also been criticised in a similar way to the IMF through promoting market-orientated national health systems; recommending privatisation, user fees, private insurance, etc.

The WTO has also been the subject of widespread concern from the health community. Although only a few countries have made commitments to liberalise their health sector specifically under the General Agreement on

Trade in Services (GATS), other commitments have been made that may impact upon health and health care, such as within the finance and insurance sector.[23] Health is also seen as the next major sector to be negotiated, with many developing countries seeing this as an area of comparative advantage and one which they may be able to trade for beneficial commitments in other sectors, such as agriculture.[24] Given the isolation from this system of the heath profession in general, and the WHO specifically as outlined above, there is anxiety that trade and economic interests will therefore override health concerns.[25]

COMMERCIAL PRIVATE SECTOR

The commercial (for profit) private sector has clearly increased in influence among global players with the emergence and consolidation of TNCs, which, through merger and oligopoly behaviour, exert far more economic power than many nation states. As outlined earlier, the largest 200 TNCs have revenues greater than 182 of the world's nations, or 80 percent of the world's population.[26] As also noted earlier, the influence of the commercial sector on health and the health sector mean that the relative power of these bodies compared with nation-states or inter-governmental bodies is a key shift in global health governance in recent years.

An example of how a large commercial enterprise can use its economic power to manipulate and override the health governance of a nation-state is provided by Gilmore.[27] In their study of British American Tobacco (BAT), the privatization of state-owned tobacco in Uzbekistan in 1994 enabled BAT to establish a production monopoly. During this process, Uzbekistan's chief sanitary doctor issued Health Decree 30, which would have banned tobacco advertising, banned smoking in public places, and introduced health warnings. BAT's response was to delay completion of its investment until this piece of health legislation, which would have protected the health of the Uzbek population, was overturned and replaced with a "voluntary advertising code." BAT succeeded in successfully overturning bans on tobacco advertising and smoking in public places, and significantly reducing cigarette excise rates. The result has been that, since 1994, tobacco consumption has increased by some eight percent annually, primarily among young people, and BAT's market share is now over 70 percent.

This situation is not confined to this case. There are reports of similar situations, with other companies, in other former Soviet countries and developing nations. Such examples highlight the ability of TNCs to override, manipulate, or avoid national health policy, especially when they invest in low-income countries. This ability of tobacco companies especially to shape national health policy takes on greater relevance to the debate on global health governance as it is set within the context of WHO's first public health treaty, the Framework Convention on Tobacco Control (FCTC). The FCTC has successfully provided the first tentative move to a system of governance and regulation of a harmful consumer product on a global basis. However, could the FCTC provide a template for global health governance elsewhere, or do examples such as that in Uzbekistan suggest that the commercial sector provides insurmountable obstacles? Although the FCTC has accelerated policies on tobacco control in participating countries, it also heightens

opportunities for tobacco companies to shape legislation or to encourage the pre-emptive adoption of ineffective measures.[28]

The commercial (for profit) private sector also plays an increasingly prominent role in the health sector itself. Traditionally, the large corporate presence in the health sector has been the pharmaceutical industry. Here the world's top pharmaceutical corporations are all multinational, and together the top 10 (Pfizer, GlaxoSmithKline, Novartis, Sanofi Aventis, Johnson & Johnson, Astrazeneca, Merck & Co, Roche, Abbott, and Amgen) account for just under 50 percent of the world market, and the top 20 account for some 65 percent.[29] A core global governance concern for pharmaceutical companies is patenting, as it is this that determines the revenues, and hence profits, that they are able to generate from new products. On the global level, the focus for intellectual property rights and patents has been the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).[30]

The TRIPS Agreement came in to effect in January 1995 and established global minimum standards for the protection of intellectual property, including patents on pharmaceuticals, as well as addressing other issues such as international cooperation against drug counterfeiting. Under this agreement, since 2005, new drugs are subject to at least 20 years patent protection (with the exception of a few least developed countries and non-WTO Members, such as Somalia). The TRIPS Agreement thus dramatically elevated and expanded intellectual property rights (IPRs) in the area of pharmaceuticals, including rules on the protection of test data about efficacy and safety of drugs. It is the result of many years of intense lobbying by the industry within the various global fora of relevance, such as the WTO, as well as national governments, and provides a good example directly within health of how commercial concerns are influencing national health systems through their impact on global health governance.[31]

A further, related, aspect of this issue concerns the provision within TRIPS (Article 8) for Members to "adopt measures necessary to protect public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development," and for exemptions from patentability, the possibility to make limited exceptions to patent owners' exclusive rights, compulsory licensing, and parallel importation. These measures were designed to appease the concerns that the extension of patents laws could be detrimental to some national health systems. However, rather than lead to a flexible adoption of TRIPS, industry power is such that measures that circumvent TRIPS, involving even more stringent standards, are being lobbied for, termed "TRIPS-plus" measures. These involve bilateral trade agreements in which protection standards for IPR are incorporated that go beyond TRIPS in exchange for trade concessions, such as the promise of access to rich markets for agricultural goods, as a *quid pro quo*. Such agreements between developing countries and, especially, the US, European Free Trade Area, and the European Union have become increasingly prevalent in recent years. Again, this is a prime example of how commercial interests are increasingly shaping – or in this case circumventing – global health governance.[32]

NON-COMMERCIAL PRIVATE SECTOR

The non-commercial private sector – the typical non-governmental organization (NGO) – has also been influenced by the change in economic power. Many NGOs are now the product of, or influenced by, wealthy philanthropists. The Bill and Melinda Gates Foundation is the most obvious example, awarding international health grants of $895 million in 2005, which accounts for over 60 percent of all private aid, worldwide, for health and is equal to more than half of the expenditure of WHO. However, they are not the only example. The Ford Foundation gave $24 million in health grants in 2005, the Rockefeller Foundation $22 million, the David and Lucile Packard Foundation $18 million, the William and Flora Hewlett Foundation $13 million, the John D. and Catherine T. MacArthur Foundation $10 million, the Merck Company Foundation $10 million, the Bristol-Myers Squibb Foundation $10 million, the ExxonMobil Foundation $9 million, and the Starr Foundation $8 million.[33]

Whilst these new actors have dramatically increased the funds available for investment in global health, they not only set the agenda for their own foundations but also, more indirectly, for much of the "aid market."[34] Through this, these wealthy individuals or corporations exert significant influence over global governance in health.

Perhaps the most significant in this is the Global Fund against AIDS, Tuberculosis and Malaria (GFATM), a partnership created in 2002 between donor and recipient governments, non-governmental organizations (NGOs), the private sector (including businesses and philanthropic foundations), civil society, and affected communities. The purpose of the GFATM is to attract and disburse resources to prevent and treat AIDS, tuberculosis (TB), and malaria. It relies on local ownership and planning to ensure that these resources are directed to the most appropriate programmes, with grants awarded on a performance-based approach.

The GFATM was born of frustration, especially on the part of AIDS activists, that good ideas from the field were not receiving deserved support because of donor red tape.[35] The response was to be a funding agency which would not assess proposals itself, relying rather on an independent panel, and would use local accounting firms to monitor implementation. Its comparative advantage would be focusing resources quickly on 'best shot' programmes in countries with the greatest need. The hands-off approach to program formulation and implementation, it was argued, would mean that the GFATM would have no agenda of its own; aid-recipient countries would be able (through their representation on the review panel) to set their own priorities. The absence of a programmatic/operational agenda would allow the Fund to concentrate on mobilising and disbursing resources.[36]

However, it would be naïve to assume that an organization with several billion dollars to award in grants will not have an impact on the global health agenda – critically, the agenda has been moved more toward the three areas of concern of the GFATM at perhaps the expense of other areas, such as non-communicable disease. Indeed, it is debatable whether the funds raised are additional, as there are suggestions that the arrival of GFATM in some countries has led many bilateral donors to limit their own efforts.[37]

The importance of these organizations is not just that they influence *how* global health priorities are financed, but also *what* is financed; that is, which priorities are financed. These are predominantly disease oriented, rather than focused upon health system or social determinants of health,

mostly concerned with curative than preventative services, and on communicable rather than non-communicable disease.[38] A good illustration of this is provided in comments by Kickbusch[39] on the Bill and Melinda Gates Foundation, where she states that: "An ad hoc response system run on good will and philanthropic largesse like [the Bill and Melinda Gates Foundation] can only be an intermediary step. Already the law of unintended consequences is starting to have its effect. Newly established global disease investment funds, run from office suites in New York, Washington, Geneva and Brussels are set to fundraise, compete and conquer, each seeking contributions in the billions of dollars from the same sources for 'their' disease." It is perhaps unfair to single out the Bill and Melinda Gates Foundation, but this is a classic case where the foundation – especially as it is so well resourced – supports global health development in areas of *their choice* (vaccine development and maternal and child health), but with massive ripple effects elsewhere.

CONCLUSION

Governance concerns rule making, and rule making is shaped by power relations.[40] As indicated in the introduction, these relationships may involve military, political, ideological, and/or economic power. [41] Within an increasingly global economy, we have seen the trans-nationalisation of economic power from nation states to non-state actors. We have also seen a shift from national to international legislative institutions and agreements, on a regional and increasingly on a global level. Much of this development has been influenced by the prevailing economic powers.

Against this changing landscape of global governance, global health governance has also been affected, including especially the move in to health of traditionally non-health global institutions, such as the WTO or IMF, and the influence of wealthy individuals in setting the health agenda.[42] All of these developments signal a seismic shift in health governance from nation-state public health institutions to global non-public sector bodies.

For some, this no doubt signals the final victory of the "dismal science" and the inevitable diminution of health for economic gain. However, this is not what this paper argues. Rather, to engage in the advancement of health one needs to be aware of the governance context that one is seeking to influence and to seek opportunities within that as well as reduce risks arising from it. For example, in some camps SARS was heralded as "the best thing to happen to public health in years." This was not because it had a huge impact on health, but because the world's economic system and players felt the impact.[43] This parallels the cholera epidemics of the 19th century. There, national governments initiated the International Sanitary Conferences not because the health of many poor people was being affected, but because it threatened to disrupt trade and the industrial revolution. That is, economic factors were instrumental in the development of international health governance. Indeed, one could suggest that it is only when we see *economic* power threatened in some way (e.g. the feedback from its own externalities) that we see global *health* governance initiatives.

SARS, and current concerns surrounding outbreaks of Avian Influenza or other infectious diseases, has increased the visibility of infectious disease, and hence the need for investment in surveillance and in tackling the

emergence of outbreaks where they occur (i.e. investment in countries with poor health systems and health structures). In this sense, SARS provides a concrete example demonstrating how the public health community can harness the concerns of global economic governance institutions and utilise these to their advantage, as well as demonstrating the power of global health governance institutions, especially the WHO, who, in that case, were clearly the fulcrum of global health governance.[44]

Together with mounting evidence concerning the impact of environmental and social degradation, the health community is perhaps experiencing a time of opportunity on the world stage for influencing the agenda, not just in health care but also in wider areas that influence health.[13]For instance, it is becoming ever clearer that the global economy is unsustainable without appropriate social, health, and environmental protections. The public health community is ideally placed to capitalise on this development and to reassert itself, through its scientific knowledge and history of action, in global health governance. It may do this through a number of avenues, although engaging more closely with the economic governance landscape is one that is perhaps left on the periphery of activity. However, it is also one of the most significant dimensions of power within governance, having increasing relevance to, and impact upon, health, and is a dimension to global health governance that the public health community needs to better understand to minimise the risks and maximise the opportunities that this offers for improving global health. If it does not, the danger is that global health governance will increasingly be determined by economic institutions with the principle concern not of health but of market liberalisation, ultimately constraining national health system sovereignty.

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