Global Health and Globalisation

Lecture 6
Social Determinants of Health and Health Inequalities

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Complex problems have simple, easy-to-understand wrong answers

Henry Louis Mencken

Recap of Lecture 5

Historical look at the development of the 'international health' and 'global health' discipline

In low income countries, inter-twining of health and post-colonial development policy

Immediate post-colonial health challenges

Recap of Lecture 5

International Health: associated with …	Global Health: associated with …
… health in poor countries and the role of international aid and assistance	… health in all countries
… inter-country cooperation around health issues of mutual concern	… supra-national concerns about health
… clinical and public health approach to prevention and treatment of diseases	… transcends the nation state (trans-national)
… governments and inter-governmental organisations	… more complex set of actors

Recap of Lecture 5

Repeated tension between narrow, selective , bio-technological and vertical approach with a broader and more comprehensive approach

Selective PHC	Comprehensive PHC
Narrow: bio-technological and targeted	Broad: multi-sectoral
Cost effective and efficient	Cost-effective, appropriate and sustainable
Pragmatic and practical	Normative, social, economic and political
Save lives	Empower communities
Humanitarian	Developmental
Top-down and vertical	Bottom-up and holistic
Discrete, clear and measurable	Diffuse and messy
NGO led	State led

Debt Crisis and Structural Adjustment

- Rise in oil prices
- Heavy lending
- Rise in interest rates

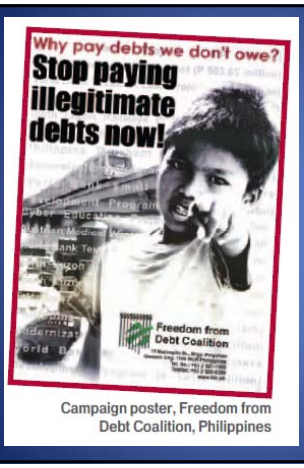
- Many LICs experienced reduced export demand, declines in primary commodity (non-fuel) prices, deteriorating real terms of trade, lower capital inflows, economic recession and soaring debt service payments.

- Many countries had negative economic growth, reduced government revenue and increasing poverty.

Debt Crisis and Structural Adjustment

- Loans and structural adjustment programmes
  - Cut back on public expenditure
  - Privatise and liberalise
  - Health sector reform
    - Drop in public health budgets
    - Public sector HWs
    - User fees and community insurance
    - Privatisation
    - Selective PHC

IMF and World Bank



Campaign poster, Freedom from Debt Coalition, Philippines

Major international campaign

Jubilee Debt campaign

- **petition calling for the cancellation of debts was handed to the Secretary-General of the UN (over 24 million signatures - world's biggest petition and the most international petition, with signatures from more than 166 countries)**

HIPC Initiative

Box E6.1 Zambia: inflation or death?

Zambia qualified in 2000 to become eligible to receive up to 50% reduction in its huge external debt of US$ 6.8 billion as a possible beneficiary of the Heavily Indebted Poor Country (HIPC) initiative. First it had to follow the IMF's loan conditions satisfactorily for three years, including a strict cap on the government's wage bill – no more than 8% of its gross domestic product (GDP).

However, the Zambian government – the country's biggest employer – faces a worsening brain drain of skilled professionals. It introduced a housing allowance system that made staying and working in Zambia more attractive. Other measures also increased the wages bill, raising public sector wages to 9% of GDP and exceeding the 8% agreed with the Fund. So Zambia was considered off track with its loan programme and was suspended from eligibility for debt relief. This means it will continue to pay close to US$ 300 million in annual debt service payments to foreign creditors in rich countries. If this issue is not resolved, even larger payments will be expected later.

The Fund says Zambia can get back on track by reducing the budget deficit to not more than 3% of GDP and the public sector wage bill to not more than 8%. It must also privatize its remaining public utilities and state-owned companies in the energy and telecommunications sectors. The monies realized from the sale of the utilities and companies must be used for increased debt servicing, not for investment or consumption.

The Zambian government is at a crossroads. If it pleases the Fund it is likely to provoke industrial unrest by workers opposed to privatization. If it seeks to maintain public ownership it will miss its chance of debt relief. Either way, it cannot raise the wage bill high enough to retain the teachers and health professionals needed to fight HIV/AIDS.

Why? Because the IMF fears inflation.

(*Source*: Bretton Woods Project 2004)

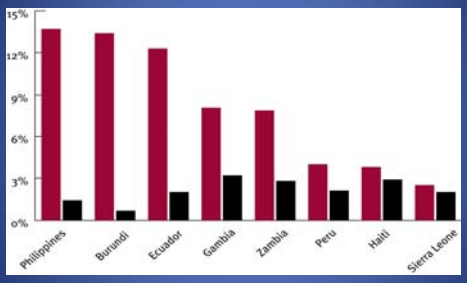
DEBT RELIEF THE IMF WAY: WHAT STICKING TO NEOLIBERAL POLICIES REALLY MEANS

Zambia: The IMF refused to allow the Zambian government to employ more healthcare workers, even when the Canadian government offered to foot the bill for five years, because it would have meant exceeding IMF spending limits

Malawi: When drought caused food shortages, the Malawian government was forced to borrow money from domestic banks to save the lives of its citizens. The IMF regarded this decision as irresponsible and declared the country to be 'off-track' from the debt relief program.

Ecuador: In 2004 Ecuador spent 12% of its GDP repaying debts and just 3.2% on healthcare and education. In 2005 the government decided to allocate 10% of the profits from a new oil pipeline to fund these public services – against IMF instructions. The IMF and World Bank responded by cancelling an already approved loan; declaring that too much of Ecuador's oil revenue was being spent on education and healthcare initiatives and not enough on paying back its creditors.

UNDP Human Development Report, 2004



Debt repayments Spending on healthcare

ECUADOR: A DECISIVE DEFAULT

In 2008 Ecuador became the first country to hold an official debt audit; a massive, year-long investigation to ascertain the legitimacy of their nation's debt. The process educated Ecuadorian society as to the impact of neo-liberalism on their country and empowered activists.

The Debt Audit Commission, which oversaw the process, concluded that foreign loans had caused 'incalculable damage' to Ecuador's economy, finding that nearly 70% of the national budget had to be diverted towards servicing debts in some years and that from the 1980s onwards 86% of new loans were used to pay debts.

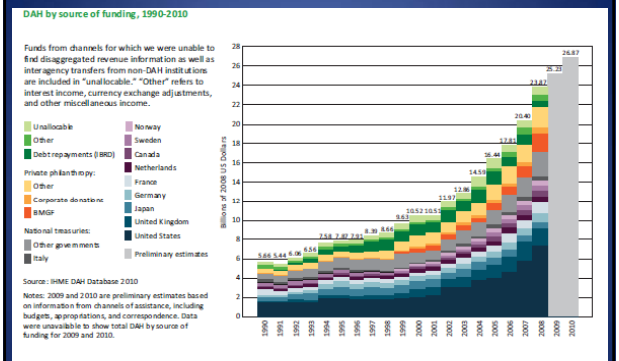
Overall the Commission considered that the loans and their impact broke multiple principles of international and domestic law and that the Ecuadorian government was forced to act in the interests of the financial system and transnational corporations rather than its citizens.

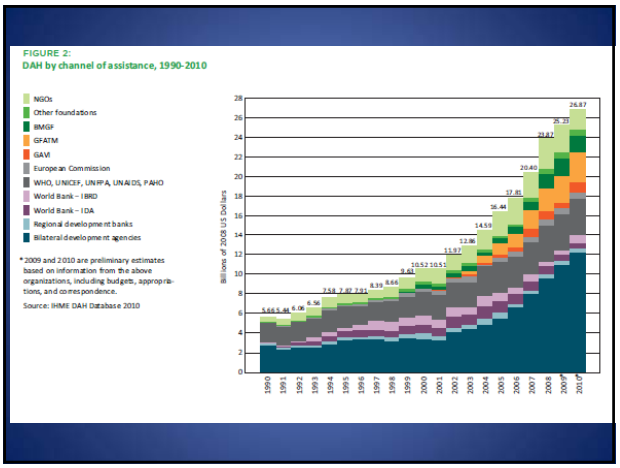
In December 2008 the government of Ecuador announced it would default on debts found to be illegitimate. Ecuador subsequently achieved a reduction in its debt burden and will now have more money to spend on its people. Audits are now planned in several other developing countries including in Bolivia and Brazil.

Framing Global Health as a Development / Political-Economy Issue ....

Other Ways of Framing Global Health ....

Global health as aid ....

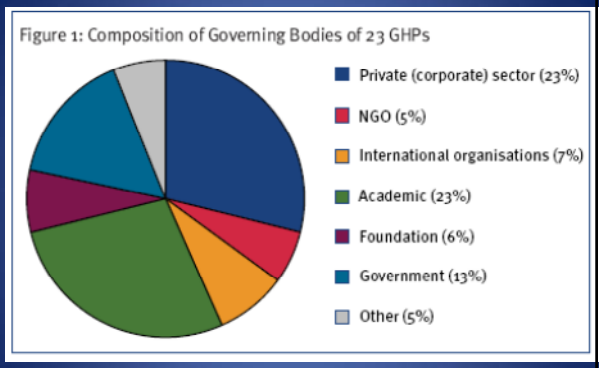




Global Health Partnerships

- Relatively new feature of the global health landscape
- Often consist of governments, UN bodies, businesses and CSOs working together through a secretariat
- Examples include the Global Fund to Fight AIDS, TB and Malaria, the GAVI Alliance, and Roll Back Malaria
- Part of a wider partnerships paradigm or 'complex multilateralism'
  - promoted as a solution to perceived failings of inter-governmental cooperation
  - harnesses CS energy and business acumen in support of 'more nuanced and potentially more effective policymaking' and more effective and efficient delivery

- Buse and Walt (2000):
  - "a collaborative relationship which transcends national boundaries and brings together at least three parties, among them corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour".
- Buse and Walt (2004):
  - "cross-border, institutionalized and cooperative collaborative arrangements between state (governments and international organizations) and non-state actors (business corporations, non-profit organizations, philanthropic bodies) which are characterised by shared burdens of risk and a division of labour"



Why have GHPs emerged?

- Disillusion with the UN
  - Ineffectiveness, overlapping mandates and interagency competition, bureaucracy
- Lack of support for the UN / Undermining of UN
  - Policy of zero real growth and shift towards tied funding
  - Not responsive to donor interests
- Part of 'neoliberalism' and growth in political influence of TNCs
  - gain control of global rule setting and influence global regulatory institutions;
  - prevent the institutions from taking an anti-business stance;
  - gain legitimacy from association with the respected UN agencies ('blue-washing')
  - Help gain access to 'markets of the poor'
  - co-option of civil society actors
- The UN and public sector needed it
  - There was an "honest recognition by the public sector" of the "unique, unrivalled monopoly" of the pharmaceutical industry … "They own the ball. If you want to play, you must play with them" (quoted in Buse and Walt 2000a)
  - Need for new medicines

Part of a bigger trend

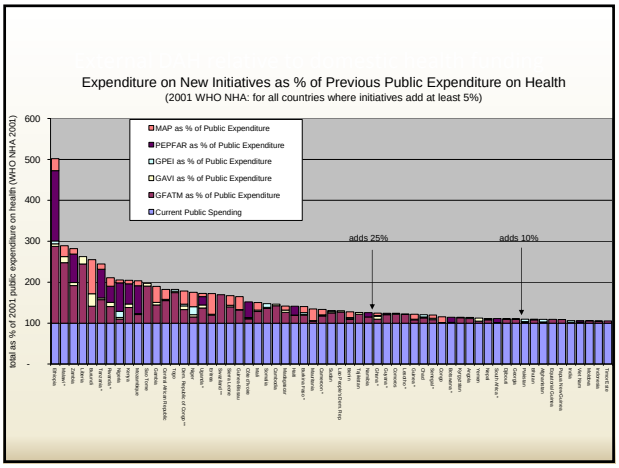
- *"In today's interdependent world, the United Nations and the private sector need each other".* UN Secretary-General Kofi Annan, 1998
- In 1998, UN and International Chamber of Commerce produced a joint statement proposing that "broad political and economic changes have opened up new opportunities for dialogue and cooperation between the United Nations and the private sector".
- A year later, Annan proposed that industry and the UN enter into a "global compact of shared values and principles, which will give a human face to the global market" and broadened the sphere of mutual interests to human rights, labour standards and environmental practice. The ICC responded positively, but suggested that the compact address a fourth value: "the economic responsibility incumbent upon any company to its customers, to its employees and to its shareholders"

Effects?

- Global Governance and Inter-Governmental Relations
  - opened up space for civil society / more democratic models of global governance
  - diluted authority of the UN / governments
  - private actors increasingly involved in rule-making and standard-setting
- Health improvement
  - Raise profile of certain diseases, in part through brand-building and public relations. Mobilised funding commitments by allocating more resources to advocacy and communications.
  - New drugs in the pipeline
  - Fragmentation, duplication and verticalisation
  - Marketisation of GHG
    - Competition between GHPs
    - Segmentation: GPPIs favour intervention in weak but stable states, leaving IGOs in conflict zones, fragile states

Effects?

- Studies by Ollila and Shiffman show that PPPs are powerful actors in setting the global health agenda but
  - priorities do not always correspond to the highest burden of disease in developing countries (Shiffman)
  - priorities are too much focused on sub-Saharan Africa (Ollila)
  - priorities too much targeted towards communicable, infectious diseases



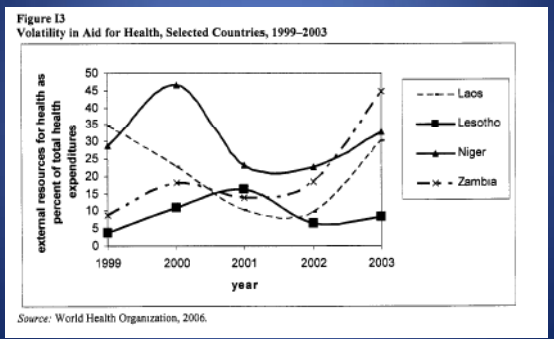
Examples of the complexity of aid

- WHO has 4,600 separate agreements with donors and has to provide 1,400 reports to donors each year
- Uganda has over 40 donors delivering aid in-country. It had to deal with 684 different aid instruments and associated agreements between 2003/04 and 2006/07
- Cambodia and Vietnam received 400 donor missions in one year, Nicaragua 289, Bolivia 270, Bangladesh 250
- In Vietnam, 11 UN Agencies provide between them only 2% of aid
- St. Vincent, population of 117,000, was asked to monitor 191 indicators and Guyana 169 indicators on HIV/AIDS

Non-DAC aid

- Recent emergence of a significant number of non-DAC donors, in particular from Asia, especially after tsunami
  - Non-DAC donors, most of them Asian, provided 12% of humanitarian aid between 1999 and 2004
  - Korea and Turkey reported aid figures larger than two DAC members in absolute terms in 2004
- China
  - $1.5 – 2 billion / year
  - third largest donor of food aid in the world
- Saudi Arabia
- India considering increasing its provision to Africa by ten times
- Cuba

Aid can be unpredictable, short-term and volatile



Issues about DAH

- Fragmentation
- Verticality
- Selectivity
  - Diseases
  - Technology
- NGO-isation / Internal Brain Drain
- Serves donor country interests (boomerang aid)
- Volatility
- Policy tensions
  - Results versus Assistance
  - Now versus tomorrow
  - Public versus private

2005 - Paris Declaration on Aid Effectiveness

- Five principles
  - National ownership
  - Alignment with national systems
  - Harmonization between agencies
  - Managing for results
  - Mutual accountability

Includes specific targets

- two-thirds of all aid should be provided in the context of programme aid approaches
- *Halve the proportion of aid* flows to the government sector that is NOT reported on partners' national budgets
- 40% of all donor missions should be joint with others
- *Halve the proportion of aid disbursements* that are NOT released according to agreed schedules in annual or multiyear frameworks

Other Ways of Framing Global Health ....

Global Health as Engine for Economic Growth

Commission on Macroeconomics and Health

Other Ways of Framing Global Health ....

Global Health as Trade / Business

General Agreement on Trade in Services

- WTO agreement adopted in 1995
- Sectoral commitments on liberalising trade, opening up market access and ensuring equal treatment for foreign companies as exist for domestic companies
- Based on 4 modes of supply

The Wellcome Trust Meeting

Rural health challenges in resource poor countries
Developing the research agenda

A view of the industry:
GE Healthcare International

Jean-Yves Burel
VP Enterprise & Market Development
London, September 25 '07

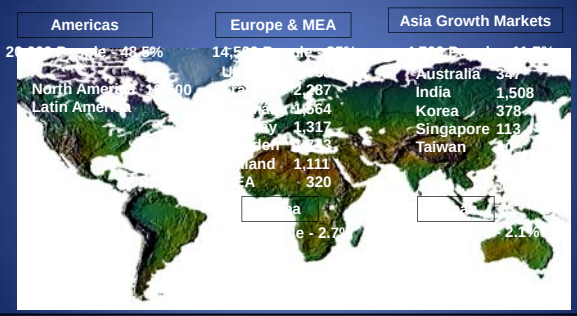
This is GE ……

- Founded by Thomas Edison in 1878
- Only company listed in the Dow Jones today that was in the original index in 1896
- 6 strategic businesses, operations in over 100 countries; 325,000+ employees
- 2006 Revenue ~ 163B$
- AAA notation. Standard & Poor's

This is GE Healthcare

Diagnostic Imaging	From Anatomical Imaging to Molecular Imaging	CT, PET/CT MR X-ray
Medical Diagnostics	From Organ to Cellular	Contrast Agents Molecular Diagnostics
Clinical Systems	From Modular, Hard Wired to Miniturization and Connectivity	Ultrasound Critical Care Systems Anesthesia Systems
Information Technology	From PACS to Clinical IT Systems	PACS RIS HIS CIS…
Services	From Maintenance to Hospital Productivity	Performance Solutions Multi-Vendor Services Asset Management
Life Sciences	From Molecular Discovery to Clinical Application	Discovery Systems Protein Separations

GE Healthcare - Global Presence

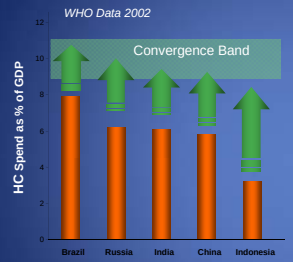


Strong Global Commitment: >50% of Resources Outside US

"Resource poor countries"

- A large market
- Growing fast
- With specific needs

Emerging Markets HC Spend



Expect Convergence at 9-11%

- *Growing economies*
- *Undeveloped HC infrastructure*
- *Social concerns/population expectations*

✓ *Privatization* ✓ *Telemedicine*
✓ *Outsourcing* ✓ *Medical Tourism*

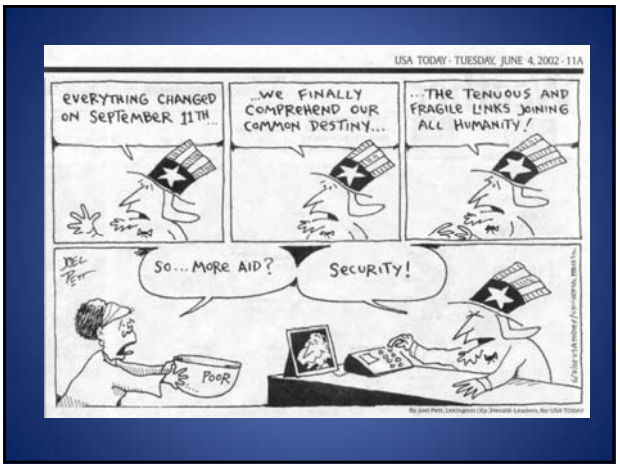
- **+2 pts Hc spend as % of GDP**
- **2/3 of current GDP growth**

+ $100B Market Growth

Other Ways of Framing Global Health ….

Health as Security: Securitisation of health

- Health aid seen as a means by which to assert more control / protect security and vital interests
- Poor health also seen as a cause of instability
  - HIV/AIDS and other health issues increasingly framed as a security issue, rather than a development, public health or human rights issue
  - Greater role of State Department and DoD in US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EVERYTHING CHANGED ON SEPTEMBER 11TH...
...WE FINALLY COMPREHEND OUR COMMON DESTINY...
...THE TENUOUS AND FRAGILE LINKS JOINING ALL HUMANITY!
SO... MORE AID?
SECURITY!
POOR