Globalization and Health Knowledge Network:
Research Papers

WHO Commission on Social Determinants of Health

Globalization, Global Governance and the Social Determinants of Health:

A review of the linkages and agenda for action

Globalization Knowledge Network

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Preface

The Globalization Knowledge Network (GKN) was formed in 2005 with the purpose of examining how contemporary globalization was influencing social determinants of health. It was one of nine Knowledge Networks providing evidence-informed guidance to the work of the World Health Organization's Commission on Social Determinants of Health (2005-2008): like most of the Knowledge Networks, its operations were financed by an external funder (in this case, the International Affairs Directorate of Health Canada, Canada's national ministry of health). The GKN conducted two face-to-face meetings to debate, discuss, outline and review its work, and produced thirteen background papers and a Final Report. These papers and the Final Report underwent extensive internal and external peer review to ensure that their findings and policy inferences accurately reflected available evidence and scholarship.

This GKN publication series was prepared under the general editorship of Ronald Labonté, with assistance from Vivien Runnels and copy-editing provided by Wayne Harding. All views expressed are exclusively those of the authors. A complete list of titles in the publication series appears on the inside back cover of this monograph.

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Table of Acronyms

CAC	Codex Alimentarius Commission
CCA	Common Country Assessment
CSDH	WHO Commission on the Social Determinants of Health
CSO	civil society organisation
DESA	UN Department of Economic and Social Affairs
EB	Executive Board
EBF	extra-budgetary funds
ECOSOC	UN Economic and Social Council
EPI	Expanded Program on Immunization
ESCAP	UN Economic and Social Commission for Asia and the Pacific
FAO	Food and Agriculture Organization
FCA	Framework Convention Alliance
FCTC	Framework Convention on Tobacco Control
G8	Group of Eight countries
G20	Group of Twenty countries
G77	Group of 77 countries
GAIN	Global Alliance for Improved Nutrition
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GAVI	Global Alliance for Vaccines and Immunization
GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFHR	Global Forum for Health Research
GHG	global health governance
GKN	Globalization Knowledge Network
GMO	genetically modified organism
GPG	global public good
GPPI	Global Public Policy Institute
GPPN	global public policy network
GPPP	global public-private partnership
HFA	Health for All
HRBA	human rights-based approach
IDPF	International Drug Purchasing Facility
IEA	International Energy Agency
IFAD	International Fund for Agricultural Development
IFF	International Finance Facility
IFI	international financial institution
IFFI	International Finance Facility for Immunization
IFPMA	International Federation of Pharmaceutical Manufacturers Associations
IFRC	International Federation of Red Cross and Red Crescent Societies
IHR	International Health Regulations
ILSI	International Life Sciences Institute
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
INGOs	international nongovernmental organizations
IPRs	intellectual property rights
ISO	International Organization for Standardization
ITGA	International Tobacco Growers' Association
IUATLD	International Union Against Tuberculosis and Lung Disease

LMICs	low- and middle-income countries
MDGs	Millennium Development Goals
MTA	multilateral trade agreement
NEPAD	New Partnership for Africa's Development
NGO	non-governmental organization
NIEO	New International Economic Order
NIH	US National Institutes of Health
OECD	Organization for Economic Co-operation and Development
PEPFAR	President's Emergency Plan for AIDS Relief
PHM	People's Health Movement
PRS	Poverty Reduction Strategy
RBF	regular budget funds
RTH	right to health
SARS	severe acute respiratory syndrome
SDH	social determinants of health
SPS	sanitary and phytosanitary measures
SWAp	sector-wide approach
TBT	technical barriers to trade
TNC	transnational corporation
TRIPS	Agreement on Trade-Related Intellectual Property Rights
TTC	transnational tobacco company
UDHR	Universal Declaration of Human Rights
UNAIDS	Joint UN Programme on HIV/AIDS
UNCTAD	UN Conference on Trade and Development
UNDAF	UN Development Assistance Framework
UNDP	UN Development Programme
UNEP	UN Environment Programme
UNFPA	UN Population Fund
UNICEF	UN Children's Fund
UNRISD	UN Research Institute for Social Development
WCSDG	World Commission on the Social Determinants of Globalisation
WEF	World Economic Forum
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WIDER	UN World Institute for Development Economics Research
WIPO	World Intellectual Property Organization
WSF	World Social Forum
WTO	World Trade Organization

Executive Summary

As processes of globalization have accelerated in recent decades, there have been widespread efforts to develop appropriate forms of governance to deal effectively with emerging worldwide challenges. This paper reviews the existing evidence concerning the impacts of global governance on the social determinants of health (SDH). First, it documents the transition taking place towards global governance related to the SDH in terms of institutional actors, and their relative roles, power and authority. Second, it assesses how emerging forms of global governance may be influencing the SDH. How might various institutions, and the distribution and use of power and authority among them, affect the SDH? Third, this paper assesses the quality of emerging forms of global governance against recognized "good governance" criteria. Fourth, it identifies how global governance can play a transformational role in addressing the SDH.

The analysis suggest that the SDH are not well served by the current system of global governance, either in the field of health or more generally. The emergent global governance architecture relevant to the SDH is characterized by the following:

- "Thick" governance in certain issue areas, notably economic relations such as trade, investment and finance, but "thinner" governance in other issue areas, notably the social sectors. Despite increased recent attention to selected global health issues, resulting in the creation of various individual initiatives, addressing the SDH has not yet been given sufficient priority in the building and running of effective global governance institutions.
- The relative balance of power among state, market and civil society institutions has shifted radically in recent decades. The private sector (market) and civil society have gained more prominent roles at the global level, including institutions concerned with global health, while state institutions have seen a relative decline.

- Within each type of institution, there is a greater concentration of power in fewer hands at the global level. Large transnational corporations, major industrialized countries and mostly Northern-based "international" non-government organizations have come to dominate global governance, while many remain marginalized by the current architecture. Economic globalization defined by economic growth has been prioritized over social and environmental protection.
- A certain degree of innovation has characterized some mechanisms in global institutions concerned with the SDH. However, these innovations to broaden representation in global governance with non-state actors, most notably the corporate sector, have been accompanied by the simultaneous reduction of the power of competent UN bodies. And in that way they have been conducive to further fragmentation and confusion of global governance on these essential health issues.

Through poverty reduction strategies and the MDGs, there has been increased attention to the SDH within a number of institutions. However, there remain concerns that these initiatives have lacked genuine commitment and been narrowly interpreted in their implementation, focusing on technical interventions and measurable outcomes rather than on underlying structural factors. The focus of many GPPPs is on disease-oriented activities and biomedical interventions, as opposed to changing the broader structural conditions which affect the SDH. Where powerful non-health interests prevail, there are profound difficulties in gaining sufficient attention and political priority for health issues in general and for the SDH in particular.

This paper's review of selected global institutions, against key criteria of good governance, points to a number of weaknesses that are detrimental to tackling the SDH:

- The long-standing *problems of coordination and coherence,* characterizing global institutions in general, extend to institutions concerned with the SDH. The resulting patchwork of institutional mandates, activities, authority and resources reflects the absence of an agreed plan or strategic vision to tackle the SDH.
- The key global institutions affecting the SDH have *inadequate systems of transparency and accountability*. A more critical assessment of transparency and accountability mechanisms is still needed. Foremost there is need for an overall system of "checks and balances" within and across global institutions to ensure collective transparency and accountability.
- There have been some efforts to *diversify representation* within global institutions concerned with the SDH, but limited efforts to *redistribute power* within them. There is a clear tension between the need to accommodate diverse perspectives, through a plurality of institutions, and the optimal use of limited resources through coordinated action. How can the SDH be served best?
- Resources for global health have increased in recent years (e.g. to GPPPs and to initiatives to strengthen cooperation on global health issues such as pandemic influenza). However, *the governance of resource mobilization and allocation has remained firmly under the control of major donors*. Decisions continue to reflect accountability to foreign and economic policy goals, and to domestic constituents which, given electoral cycles, tend to favour short-term projects and measurable outcomes.
- There is a *distinct lack of overall leadership* among global institutions affecting the SDH in terms of formally recognized authority.

There is strong evidence at the national level that good governance is an important factor in addressing the SDH. Strengths and weaknesses in national governance for the SDH might be applied to the global level where there is a need for fuller assessment of how good governance contributes to tackling the SDH.

The overall recommendation of the paper is for a fundamental review of the structure of global governance in the context of the needs, priorities and political culture of the early 21st century. Such a process would clearly need to go beyond the SDH to other concerns not recognized as priorities in the 1940s, such as environmental sustainability. However, the

SDH must clearly play a central role in the process. Building global institutional and intergovernmental support for such a large but important initiative requires WHO to promote this goal among its member nations and its global institutional partners.

More specifically the report recommends the following:

1. There needs to be more critical, detailed and systematic assessment of health and non-health focused institutions, individually and collectively, in terms of their *de facto* concern and impact on the various SDH, and the effects of their governance structures in this context. The WHO should assume institutional leadership in undertaking this assessment, working with partner institutions, CSOs and independent researchers/scholars.

2. The contemporary global governance architecture is dominated by institutional and policy perspectives that constrain action to effectively address the SDH. The first step in a reform process to correct this imbalance is development of criteria for good global governance related to the SDH, based on the assessments recommended above. Again, WHO should assume institutional leadership in this regard.

3. As an initial product of the reform process (as above), WHO member states should be encouraged to give higher priority to addressing the SDH. WHO should reflect that priority by allocating substantial and commensurate core funding, by hiring more social scientists and nurses and by building the corresponding capacity of its staff.

4. It is recommended that WHO play a lead role in providing scientific and technical support to address the SDH. This review of existing global institutions finds WHO to be the most appropriate focus for this work. However, the organization must adapt and apply its technical expertise to achieve a focused agenda which gives much greater emphasis to tackling the SDH.

5. To effectively play this role, WHO's independence from sectional interests, and the symmetry of its accountability to member states, needs to be more effectively ensured. Its conception of health and institutional structure should also move decisively beyond a vertical, disease-specific and biomedically focused model, towards a more holistic and multidisciplinary model.

6. WHO should seek a resolution for formal support of SDH and to ensure longer time frame for work and activities.

7. There is a need for stronger consensus and for more concerted coordination of relevant global institutions if the SDH are to be tackled effectively. It is recommended that ECOSOC be strengthened and, together with WHO, formally tasked to oversee such work, with relevant UN organizations including WHO reporting to it.

8. CSOs can better coordinate their actions aimed at influencing the key global institutions affecting the SDH.

9. The human rights-based approach should be used as an analytical and normative framework and advocacy tool in support of the SDH by WHO and other multilateral institutions.

10. Global institutions whose policies impact significantly on the SDH, notably WHO, the World Bank, IMF and WTO, should be required to include health ministries and relevant CSOs in key decision-making bodies and negotiations on issues substantially affecting the SDH.

11. Alternative financing mechanisms, more independent of political interference by individual donors, should be systematically assessed and adopted.

1.1 Introduction

As processes of globalization have accelerated in recent decades, there have been widespread efforts to develop appropriate forms of governance to deal effectively with emerging worldwide challenges. *Governance* broadly concerns the agreed actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals (Dodgson et al. 2002). Governance can be formed at different levels of social organization – local, state/provincial, national, regional and so on – and can become closely intertwined. *Global governance* can be defined as:

> the complex of formal and informal institutions, mechanisms, relationships, and processes between and among states, markets, citizens and organizations, both inter- and non-governmental, through which collective interests on the global plane are articulated, rights and obligations are established, and differences are mediated (Thakur and Weiss in press).

Global governance for health concerns (a) any institutions and practices of global governance which affect the determinants of health and (b) institutions and practices of global governance specifically created to address health determinants and outcomes.

The purpose of this paper is to review the existing evidence concerning the impacts of global governance on the social determinants of health (SDH). This requires some analysis of the nature of global governance in the early 21st century, a period of intense debate and institutional transition towards forms of governance that seek to better manage the diverse and far reaching impacts of globalization (Fidler 2005b). Despite its current imperfections and formative nature, global governance is the overarching institutional framework in which health goals are collectively agreed upon and pursued across countries. As such, this paper focuses on how global governance affects the SDH, through both direct action and more indirectly by shaping political and economic structures which influence them.

1.2 Rationale

There are four analytical tasks undertaken by this paper. First, it documents the transition taking place towards global governance related to the SDH in terms of institutional actors, and their relative roles, power and authority. This requires an understanding of the changing architecture comprising health-based and non health-based institutions. The paper examines why these shifts have occurred and assesses what influences their decision-making and actions.

Second, the paper assesses how emerging forms of global governance may be influencing the SDH. How might various institutions, and the distribution and use of power and authority among them, affect the SDH? The content of specific policies of such institutions as the World Bank and International Monetary Fund (IMF) will be reviewed. The paper seeks to understand governance of, and by, these institutions. For example, the World Trade Organization (WTO) has influenced standard-setting procedures and commercial regulation in international trade. In turn it has conferred legitimacy on the role and status of the Codex Alimentarius Commission (CAC) regarding food standards, as well as provided policy space for corporate interests seeking to influence standards adopted by the International Organization for Standardization (ISO). Similarly, decision-making processes in the Organisation for Economic Co-operation and Development (OECD) and less formal networking events, such as the World Economic Forum (WEF), shape economic policies, many of which (e.g. trade and investment, aid, debt relief) impact on the SDH.

Third, this paper assesses the quality of emerging forms of global governance against recognized "good governance" criteria. What is "good governance" and how can this be achieved at different levels of governance and by various types of institutional actors (Ball and Dunn 1997)? As Vayrynen (1999, p. xi) writes:

> most international problems today have domestic roots which spill over borders and thus threaten the security of other people; refugee flows are a case in point. Therefore, global governance cannot replace the need for good governance in national societies; in fact, in the absence of quality local governance, global and regional arrangements are bound to fail or will have only limited effectiveness. In a way, global governance has to be built from the ground up and then linked back to the local conditions.

While this cannot be a comprehensive analysis, members of the Globalization Knowledge Network selected global governance institutions deemed to exert considerable influence on the SDH or to be representative of a class of global institution. These were then assessed against the following criteria: coordination and coherence, transparency and accountability, participation and representation, resource mobilization and allocation, and leadership. It is argued that addressing poor governance within and across global governance institutions is a necessary prerequisite to tackling the SDH.

Fourth, there is a need to identify how global governance can play a transformational role in addressing the SDH. While there have been impressive improvements in health status over the past century, these gains have not been equitably shared within and across countries (Sen and Bonita 2000), and the rate of improvement has slowed in recent decades.[1] Innovative forms of global governance have emerged in recent decades seeking to address enduring and emerging health challenges. The Framework Convention on Tobacco Control (FCTC), as the first international health treaty, was enabled by innovative global governance processes involving governments, civil society and the private sector (Collin et al. 2002). A plethora of global public-private partnerships (GPPPs) have been formed. Global social movements, such as the Framework Convention Alliance (FCA), People's Health Movement (PHM) and the women's health movement have also played a prominent role. The paper concludes with recommendations on how global governance can be more equity oriented and pro-health.

[1] See Cornia G., Rosignoli S., Tiberti L. (2007), "Globalization and health: pathways of transmission and evidence of impact," Discussion Paper, Globalization Knowledge Network, WHO Commission on Social Determinants of Health.

1.3 Global governance and the social determinants of health

1.3.1 Global governance

Governance concerns the agreed actions and means adopted by a society to promote collective action and solutions in pursuit of common goals. Governance takes place whenever people seek to organize themselves to achieve a shared end through agreed rules and procedures. This can take place at different levels of decision-making and action. If a local community decides to initiate a campaign to slow traffic speed and improve road safety, this requires some form of governance to organize the effort. If a global campaign is initiated to strengthen tuberculosis control, an agreed form of governance is needed to take decisions, for example, on strategy, resource mobilization and implementation of agreed actions.

Importantly governance is not synonymous with *government:*

> Both refer to purposive behaviour, to goal oriented activities, to systems of rule; but government suggests activities that are backed by formal authority…whereas governance refers to activities backed by shared goals that may or may not derive from legal and formally prescribed responsibilities and that do not necessarily rely on police powers to overcome defiance and attain compliance (Rosenau 1995, p. 15).

This distinction between government and governance can be further understood within an historical context. The Peace of Westphalia (1648), which ended the Thirty Years War, established the modern system of nation-states. While ostensibly centred on European powers, the treaty marked formal recognition albeit uneven application of four key principles that still govern international relations today. They are the sovereignty of states and fundamental right of political self-determination; legal equality between states; international treaties between states; and non-intervention of one state in the internal affairs of another state. Over the next 350 years, the principles of state sovereignty and equality have led to the gradual formation of 192 states (recognized by the UN), each with a government exerting formal authority over its people and territory.

The broader concept of governance has gained relevance since 1945 with increased integration of the world economy, proliferation of non-state actors and globalization. As McGrew (2000, p. 130) describes:

> Contemporary patterns of globalization raise the most profound questions about how modern societies are governed and – normatively speaking — how they should be governed… What are the limits to national power and how effective is national government when the organization of economic and social life appears systematically to transcend territorial jurisdictions?

By the late 20th century the question of how to effectively govern a world where many issue areas (e.g. illicit drug trade, financial and capital flows, environmental degradation, migration) transcend national borders, elicited wide-ranging debate. Diverse perspectives have been put forth, ranging from the creation of a global government, to minimalist *laissez faire* forms of governance (Held and McGrew 2002).

Global governance is thus "the sum of the many ways individuals and institutions, public and private, manage their common affairs…[through] intergovernmental relationships…[and] NGOs, citizens' movements, multinational corporations, and the global capitalist market" (Commission on Global Governance 1995). The World Commission on the Social Dimensions of Globalization (WCSDG) defines global governance as "the system of rules and institutions established by the international community and private actors to manage political, economic and social affairs" (ILO 2004, p. 75). To date global governance can be seen as emergent in a few selected issue areas, in some cases bringing together a diversity of state and non-state actors, and leading to innovative institutional mechanisms. In other areas, global governance remains weak or nonexistent, revealing gaps in authority, regulation, resource management and, ultimately, effectiveness of collective action (Ware 2006). Importantly the nature of global governance remains the subject of considerable political dispute. While some perceive contemporary developments as progress towards more pluralist and democratic forms of governance, others have grave concerns about the concentration and

misuse of power, and the disadvantaging of certain social groups, such as the poor and women (Held 1995; Falk 1999). The nature, goals and impacts of emerging forms of global governance, therefore, remain highly contested (Barnett and Duvall 2005; Kickbusch 2003).

1.3.2 The principles of good governance

An integral part of debates about global governance is the need to achieve "good governance", a term widely used and often misused among donor agencies, practitioners, policy-makers and scholars. There is widespread recognition that current forms of global governance fall short in their capacity to manage globalization effectively. For example, the World Commission on the Social Dimensions of Globalization reports:

> the problems we have identified are not due to globalization as such but to deficiencies in its governance. Global markets have grown rapidly without the parallel development of economic and social institutions necessary for their smooth equitable functioning. At the same time, there is concern about the unfairness of key global rules on trade and finance and their asymmetric effects on rich and poor countries. (ILO 2004, p. xi)

While recognizing the need for improving the quality of governance, what precisely constitutes good governance, and how it can best be achieved, have been the subject of keen debate. There are diverse concepts of good governance because the term is invariably normative. Criteria for assessing the quality of governance range from a relatively narrow focus on administrative, technical and economic competence of specific institutions, notably of the state (World Bank 1994), to broader assessments of how well political systems, encompassing both state and non-state institutions, function as a whole (Grindle 2004). For example, the World Bank has emphasized the reform of the state as an enabler of economic growth and development, leading to a focus on reducing state corruption and strengthening public administration (Huther and Shah 1998; Ng and Yeats 1999; Wei 2000; Wolfowitz 2006). Similarly, the Centre for Global Development has sought to measure "the quality of public administration, business friendliness, and efficient allocation of public resources" (Becker et al. 2006, p. 1). The UN Development Programme (UNDP), in contrast, has adopted broader criteria for assessing good governance as integral to state, market and civil society interaction:

> Governance includes the state, but transcends it by taking in the private sector and civil society. All three are critical for sustaining human development. The state creates a conducive political and legal environment. The private sector generates jobs and income. And civil society facilitates political and social interaction - mobilising groups to participate in economic, social and political activities. Because each has weaknesses and strengths, a major objective of our support for good governance is to promote constructive interaction among all three" (UNDP 1997, Executive Summary).

An assessment of the substantial literature on good governance is beyond the scope of this analysis. In assessing the linkages between global governance and the SDH, the following observations can be made. First, the initial emphasis on the need for good governance in low- and middle-income countries (LMICs), largely promoted by international financial institutions (IFIs), has broadened to acceptance that they are criteria to which all countries should aspire. Second, governance concerns institutions across many different levels (from local to global), and aspirations of good governance should address multiple levels. Third, relatively narrow conceptualizations of good governance, focused on state institutions, have given way to recognition of the need for good governance in state and non-state institutions, including private companies (e.g. corporate governance) and civil society organizations (CSOs). Fourth, there is widespread acceptance that the appropriate criteria for assessing good governance should extend beyond measures of administrative, technical and economic competence. Criteria concerning the functioning of legal systems, democratic institutions and processes, and the development of civil society, have been added to policy debates (Leftwich 1994; AusAID 2000; Dobriansky 2003). The eight criteria framework of the UN Economic and Social Commission for Asia and the Pacific (ESCAP) is one example of broad-based principles

Box 1.

ESCAP criteria for assessing good governance

The UN Economic and Social Commission for Asia and the Pacific (ESCAP) identifies eight complementary goals as criteria for assessing good governance. The criteria are defined in the following ways:

Accountability - The requirement that officials answer to stakeholders on the disposal of their powers and duties, act on criticisms or requirements made of them and accept (some) responsibility for failure, incompetence or deceit. Accountability mechanisms can address the issues of both who holds office and the nature of decisions by those in office. Accountability requires freedom of information, stakeholders who are able to organize, and the rule of law (UNDP 1997).

Transparency – The sharing of information and acting in an open manner. Transparency allows stakeholders to gather information that may be critical to uncovering abuses and defending their interests. Transparent systems have clear procedures for public decision-making, open channels of communication between stakeholders and officials, and access to a wide range of information (UNDP 1997).

Responsiveness - Institutions and processes try to serve all stakeholders within a reasonable timeframe (UNESCO 2005).

Effective and efficient - The capacity to realise organisational or individual objectives in a way that makes optimal use of available resources. Effectiveness requires competence; sensitivity and responsiveness to specific, concrete, human concerns; and the ability to articulate these concerns, formulate goals to address them and develop and implement strategies to realise these goals (UNDP 1997).

Rule of law - Equal protection (of human rights) and punishment under the law. The rule of law reigns over government, protecting citizens against arbitrary state action, and over society generally, governing relations among private interests. It ensures that all citizens are treated equally and are subject to the law rather than to the whims of the powerful. The rule of law is an essential precondition for accountability and predictability in both the public and private sectors (UNDP 1997).

Equitable and inclusive - A society's well being depends on ensuring that all its members have a recognised stake and are not excluded from the mainstream of society. This requires all groups, but particularly the most vulnerable, to have opportunities to improve or maintain their well-being (UNESCO 2005).

Participatory - When group members have an adequate and equal opportunity to place questions on the agenda, and to express their preferences about the final outcome during decision-making. Participation could be either direct or through legitimate intermediate institutions or representatives. Participation needs to be informed and organized. This means freedom of association and expression on the one hand and an organized civil society on the other hand (UNDP 1997).

Consensus oriented - Mediation of the different interests in society to reach a broad consensus in society on what is in the best interest of the whole community and how this can be achieved (UNESCO 2005).

(**ESCAP criteria for assessing good governance cited in** UN Economic and Social Commission for Asia and the Pacific (ESCAP) 2006, p. 3)

(Box 1) that, in our opinion, adequately captures the current terrain of good governance debates.

While the substantial attention to good governance in recent decades has increased and broadened emphasis given to such issues, Grindle (2004, p. 525) argues that efforts to apply these ideas to development have been "deeply problematic":

> The good governance agenda, largely defined by the international development community but often fervently embraced by domestic reformers, is unrealistically long and growing longer over time. Among the governance reforms that 'must be done' to encourage development and reduce poverty, there is little guidance about what's essential and what's not, what should come first and what should follow, what can be achieved in the short term and what can only be achieved over the longer term, what is feasible and what is not. (Grindle 2004, p. 526)

Akin to concerns about the achievability of good governance in low- and middle-income countries, this paper recognizes the problems of rigorously applying good governance principles to emerging global governance institutions concerned with the SDH. There is uneven evidence of compliance to such principles and their attainability within and across relevant institutions may be questioned.

1.3.3 Social determinants of health

The SDH concern the specific features of, and pathways by which, societal conditions affect health. Examples include the prevailing political structure, income, education, occupation, family structure, service availability, sanitation, exposure to hazards, social support, racial discrimination, and access to resources linked to health (Marmot and Wilkinson 1999). Correspondingly, inadequate income, housing, and work environments are some of the SDH leading to health inequalities within and between countries (Wilkinson and Marmot 2003). In relation to health policy, the SDH focus on how societal conditions affect the health status of individuals, their ability to remain healthy and cope with illness and ill-health. While this includes such issues as access to health care and medical technologies, or the scope and use of public health interventions, the SDH do not deal strictly with medical and public health policies per se. Rather the focus is on the distribution of health (notably inequalities in health status) and differences in the ability to stay healthy.

Global governance issues related to the SDH are broader in scope than such challenges as access to health care and essential medicines. Institutions can promote actions on the SDH, both within the confines of health-related institutions and through institutions outside of the health sector concerned with economic, social, labour and food policies. Of concern, therefore, are the relative roles of a diverse range of global institutional actors in such policy sectors, and how they are governed.

In this respect, there is a broad range of global institutions concerned with the SDH either directly or indirectly. Most directly, institutions may address health issues explicitly, either as part of their core mandates (e.g. WHO, global health initiatives) or as an extension of them. Examples of the latter include the World Bank (development lending), WFP (emergency food relief), FAO (food security), UNICEF (children), UNDP (development) and UNFPA (population). In addition, institutions may impact on the SDH indirectly in their pursuit of non-health related activities. The policies of the Bretton Woods Institutions, for example, affect the world economy and policies in borrowing countries, and thus how different countries and populations fare within them. Similarly, trade liberalization under the auspices of the WTO may lead to positive or negative impacts on the employment prospects, working conditions or poverty rates of particular populations, as well as on sectoral policies (e.g. in health services, education and water).

From this starting point, this paper reviews evidence available to assess global governance institutions concerned with the SDH using a selection of the ESCAP principles of good governance. The principles applied are dependent on the availability of evidence for specific institutions. At present such evidence is limited, meaning that understanding the links between specific principles of good governance and individual SDH remains beyond the scope of this paper. Thus, the paper identifies priorities for strengthening research on good governance and health. It also considers the linkages between global governance and the SDH in two ways.

First, it is argued that the quality of governance (measured by good governance principles) of individual global institutions shapes the policy decisions and activities of those institutions. Are global institutions which practice good governance more likely and able to address the SDH? Can we find examples which offer lessons for strengthening emerging institutions? Second, it is argued that how these institutions collectively contribute to global governance influences the SDH. There is ample national level evidence that health depends not only, and not primarily, on medical care but also on political, economic and social interventions (Navarro and Muntaner 2004). For example, Reidpath and Allotey (2006) find that the quality of governance is a key "structural factor" for explaining population health outcomes including HIV prevalence. To what extent is the nature of the emerging architecture for global governance facilitating or hindering efforts to address the SDH? What conclusions can we draw from the quality of global governance and efforts to address the SDH?

In summary, this paper argues that global governance is central to addressing the SDH within and across countries. Along with understanding what policies are implemented or not to tackle poverty, housing, employment, and other needs (addressed in supporting GKN papers), it is critical to assess how global institutions make policy decisions collectively and individually.

1.4 Outline of paper

The remainder of this paper is organized into three main sections. Section 2 describes the emerging architecture of global governance relevant to the SDH. Section 3 assesses this emerging architecture against selected good governance criteria, recognizing "[t]he dearth of knowledge and practical tools to help identify, describe, and address governance success and failures" (Salzburg Conference 2005, p. 15). Section 4 draws conclusions and puts forth recommendations for strengthening global governance for the SDH. Examples of specific governance institutions and key issues are provided throughout to illustrate the main arguments.

2.1 The emerging architecture of global governance

Globalization has affected global governance in four fundamental ways. First, it is shifting the distribution of power and authority among different levels of governance. Globalization challenges the capacity of national institutions to govern effectively (Wapner 1995; Finnemore 1996; Gilpin 2002).[2] The result has been a growth in political and economic interactions that seek to solve problems that affect more than one state or region. While formal authority may largely remain with sovereign states, the power and authority of institutions at the regional and global levels have increased.

Second, government has traditionally delineated institutional authority and responsibility by sector, such as education, labour and health. Globalization is increasing the causal connections across different sectors, and extending causal connections long recognized at the local/national levels to the global level. This requires forms of governance that facilitate multi-sectoral and multi-level action.[3] In health, efforts have thus been made to develop approaches that cut across existing institutional boundaries to address issues of transnational reach (Martin 2006), broad goals or themes (e.g. Millennium Development Goals, poverty alleviation, social exclusion) (van Hertena et al. 2001; Kickbusch 2005). For example, efforts to tackle the HIV/AIDS pandemic have broadened from a biomedical focus to issues concerning *inter alia* human rights, poverty and gender.

Third, institutional actors are traditionally classified as belonging to the state, market or civil society (UNDP 1997). In principle state institutions hold formal power and authority in international relations, acting through intergovernmental bodies such as the UN. Globalization is changing the relative number of state, market and civil society actors (Krut 1997;

[2] See Koivusalo M., Schrecker T. (2007), Economic globalization and national health policy space. Discussion Paper, Globalization Knowledge Network, WHO Commission on the Social Determinants of Health.

[3] Ministers of Environment are in essence Ministers of Health. Environment News Service, June 17, 1999. http://ens.lycos.com/ens/jun99/1999L-06-17-06.html (accessed September 4, 1999)

Weiss 1999), and the distribution of power and authority among them. Of particular note is the growth in market-based (private sector) institutions, and their relative power within an emerging global political economy. The private sector comprises a diverse range of interests and institutions, from small-scale concerns such as local farmers and manufacturers, to large-scale global concerns such as transnational corporations (TNCs) whose operations can transcend national boundaries. Economic globalization is characterized by the growth of TNCs in number and relative size. There as been increased concentration of ownership within many sectors, such as food and drink, pharmaceuticals, electronics, automotives, energy and telecommunications (Braithwaite and Drahos, 2004). This has given them sizeable resources and capacity to influence not only the world economy but also how it is regulated through institutions of global governance. Furthermore, in some cases TNCs have become direct participants in global governance through institutional arrangements, notably global public-private partnerships (GPPPs) as discussed below.

Similarly, diverse institutions comprising civil society have become more important with global governance (Walzer 1995; Price 2003). These institutions are defined as the totality of voluntary civic and social organizations that form the basis of a functioning society as opposed to the force-backed structures of a state.[4] In health development and cooperation, civil society organizations (CSOs) have actively sought to influence policy change since the 1970s, playing an instrumental role in the adoption of the International Code on the Marketing of Breastmilk Substitutes (Richter 2002) and the essential medicines list (WHO 2001). At the UN Conference on Population and Development in 1994, the women's health movement played a prominent role in preparations and deliberations, influencing the shift in focus from population control to reproductive health (Neidell 1998). Similarly, CSOs were active contributors to the negotiation process for the Framework Convention on Tobacco Control (FCTC) (see 2.1.1).

Notably new "hybrid" institutional actors have emerged as part of global governance, bringing together different combinations of state, market and civil society actors under innovative institutional arrangements (Figure 1). Charitable (philanthropic) foundations straddle the private sector, where funding may originate, and civil society given their non-profit activities. Historically charitable foundations, such as the Rockefeller Foundation, boast an impressive record for supporting health development (Weindling 1995), although they have not formally sought prominent roles in official policy-making bodies. However, the scale of resources commanded by some foundations today, and the corresponding increase in scale and scope of their activities, suggests unprecedented influence in global health governance. For example, the Bill and Melinda Gates Foundation is among the three biggest donors to global health including its Grand Challenges in Global Health initiative (Table 2) and contributions to the Global Alliance for Vaccines and Immunization (GAVI).

Since the early 1990s there has been a multitude of initiatives that bring together state, market and civil society actors, often referred to as global public-private partnerships (GPPPs). In health these include the Global Forum for Health Research, GAVI, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and Global Alliance for Improved Nutrition (GAIN). One of the key innovations of these organizations has been to involve for-profit organizations directly in decision-making, the appropriateness of which has been questioned (Koivusalo and Ollila 1997; Buse and Walt 2000; Ollila 2003; Zammit 2003; Richter 2004). There has also been increased attention to new forms of management, with increased emphasis on results-based approaches such as payments for progress (Barder and Birdsall 2006), pilot funding, rapid measurable results, monitoring and evaluation, exit strategies, and implementation of and/or research on new technologies. There remain considerable concerns about the extent to which such approaches are appropriate to addressing the SDH, given their emphasis on short term and quantifiable measures.

Fourth, global governance in its emergent form has been characterized by shifts in, within and across

[4] Definitions of civil society vary in whether for-profit organizations should be included. In this paper, for-profit organizations and those organizations representing their interests (e.g. industry associations) are categorised as private sector actors. Civil society organizations in this paper refer to not for-profit organizations (sometimes referred to as public interest organizations) only.

countries and institutions, and resultant inequities in power and authority. Among institutions directly concerned with the SDH, the relative decline of WHO has been observed alongside the rise in prominence of the World Bank through health sector lending since the 1980s, and the proliferation of GPPPs. Beyond the health sector, the increasing power of multilateral and regional trading systems, the OECD and Group of Eight (G8) can be compared with the corresponding decline of the UN Conference on Trade and Development (UNCTAD), the Group of 77[5] and the non-aligned movement since the New International Economic Order (NIEO) debates of the 1970s.[6]

2.1.1 Case study[7]: Framework Convention on Tobacco Control

The Framework Convention on Tobacco Control (FCTC) was adopted in 2003 and, following ratification by 40 states, entered into force in February 2005. As of September 15, 2006, 168 countries have signed the agreement and 139 have become parties following ratification. The achievement of the FCTC lies not only in becoming the first international health treaty, but also in the process by which the agreement was achieved among WHO's 192 member states.

Pre-negotiation meetings were held regionally. Formal treaty negotiations were carried out through International Negotiating Body (INB) meetings held in Geneva. Public hearings were held to enable a wide range of views to be expressed. Accreditation of .CSOs was facilitated by WHO which recognized the importance of their support, not only in supporting the negotiation process, but also the subsequent signing, ratification and implementation of the FCTC within member states.

The influence of CSOs was enhanced significantly by the formation of the Framework Convention Alliance (FCA) comprised of more than 250 organizations representing over 90 countries. The FCA includes individual NGOs and organizations working at the local or national levels, as well as existing coalitions and alliances working at national, regional, and international levels. The vision of the FCA is a world free of death and disease caused by tobacco. Its mission is to promote and support a global network for coordinated international campaigning against tobacco; developing tobacco control capacity, particularly in developing countries; and carrying out effectively the watchdog function for the Framework Convention on Tobacco Control. It was created to support the development, ratification, and implementation of WHO's FCTC. It was formed out of two needs. One was to improve communication among groups already engaged in work around the FCTC process. The other was for a more systematic outreach to NGOs not yet engaged in the process, particularly in developing countries, that could both benefit from and contribute to the creation of an effective FCTC (Collin et al. 2002).

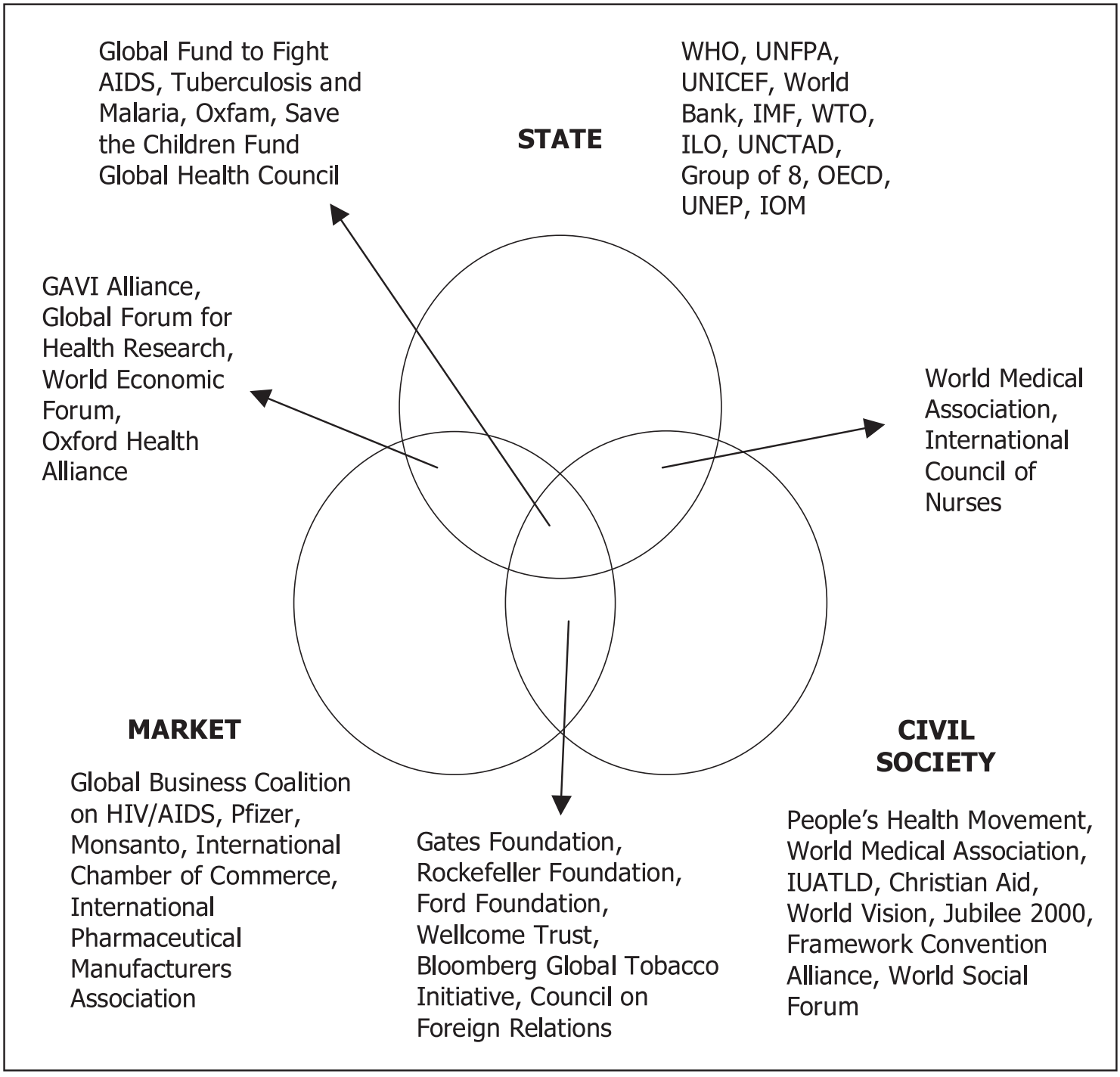
Organized around the FCA, CSOs were permitted to submit statements following each negotiation session. While not entirely satisfying, it was an advance on UN formal negotiations restricted to member states. The views of CSOs were deemed especially important to counter efforts by some governments, notably the US, Germany and Japan, to weaken tobacco control measures within the treaty. For example, the Japanese government, which owns half of Japan Tobacco International, successfully argued for extensive optional language (e.g. "appropriate measures") that seriously weakened the FCTC (Assunta and Chapman 2006). In turn CSOs presented briefings on specific issues between

5 The Group of 77 countries was founded in 1964 as a loose coalition of LMICs designed to promote its members' collective economic interests, and create an enhanced joint negotiating capacity at the UN. There were 77 founding members, with membership since expanding to 132. The G77 is modeled on the Group of 7 (now G8) countries.

6 The New International Economic Order (NIEO) was a set of proposals put forward during the 1970s by LMICs at UNCTAD to promote improved terms of trade, debt relief, development assistance, tariff reductions and other means. The Declaration for the Establishment of a NIEO, adopted by the UN General Assembly in 1974, sought to replace the Bretton Woods system with one more favourable to the developing world. Along with the declaration, a Programme of Action and a Charter of Economic Rights and Duties of States were also adopted.

7 Throughout this paper we refer to "case studies." We do not use this term in a methodological sense, which would imply triangulation of multiple data sources, including primary data. Time and resources precluded this level of systematic review and analysis. Rather, these are vignettes or "case stories," in which a reasonable though not exhaustive review of evidence and arguments pertaining to the case is used with the particular purpose of shedding light on how the example illustrates (or does not) good governance criteria, and with what known or likely effects on the SDH. Different authors of this paper have familiarity with the larger literature base on most of these cases. Together with the partial evidence cited, this allows us, with some confidence, to draw some lessons from each case, though we acknowledge that these lessons remain interpretive rather than definitive.

Figure 1: Selected global institutions impacting on the social determinants of health



negotiation sessions, as well as lobbied delegates. While these efforts were critical for catalyzing many governments into regional coalitions, notably in Africa and Asia, they did not wholly counter those governments opposed to stronger tobacco control measures.

Since the adoption of the treaty, the FCA and CSOs in general have continued to serve as a coordinating body for supporting the signing and ratification of the treaty. For example, in Central and Eastern Europe, and the former Soviet Union, Malinowska-Sempruch et al. (2006) find that CSOs have led efforts to identify direct and indirect health consequences of tobacco use. The FCA has also helped disseminate information about implementation of the FCTC, notably in low- and middle-income countries (FCA 2006).

The lessons from this case study are that a well-organized network of activist CSOs, which is able to gain official standing in multilateral negotiations, has an opportunity to argue effectively in favour of measures supporting the SDH in pertinent agreements. If CSOs mobilize and act strategically, they can exert influence through both formal and informal mechanisms.

2.1.2 Case Study: Grand Challenges in Global Health

The Grand Challenges for Global Health initiative was announced in 2003 on the basis of a US$200 million grant by the Bill and Melinda Gates Foundation for health research in LMICs. The initiative is a partnership between the Gates Foundation and the Foundation for the US National Institutes of Health (NIH), which "facilitates public-private partnerships of all sizes and configurations".[8] Following a global call for ideas, in October 2003 the initiative's Scientific Board identified 14 challenges (see Table 1) that would be the topic of a call for proposals (Varmus et al. 2003). In May 2005 the Gates Foundation added a further US$250 million in funding. In June 2005 the initiative announced grants to 43 research projects.[9]

Despite the welcome funding for global health, the initiative raises two important governance questions. First, the challenges are heavily biomedical and biostatistical, with little attention to the SDH and the policies that affect them. The initiative's original call for ideas noted that: "Although there are enormous challenges that relate to poverty, access to health interventions, and delivery systems in developing countries, this initiative is focused on the grand scientific and technological research challenges in health".[10] Second, the initiative focuses on communicable disease treatment and control, although the importance of "chronic noncommunicable disorders and…underlying living conditions" are acknowledged (Varmus et al. 2003, p. 399).

One critique of the initiative to date faults its disregard of the SDH, and proposes an alternative set of challenges as three goals (Table 2), which would "integrate social and medical/technical means of improving global health" (Birn 2005, p. 517). A similar criticism is made by Litzow and Bauchner (2006, p. 173) who write, "the issues of poor infrastructure, insufficient healthcare delivery systems, and political instability remain significant causes of child mortality and are not addressed nor supported by the Grand Challenges." The medical/technical and the SDH approaches are not mutually exclusive. The reorientation of medical research to take greater account of neglected diseases[11] has repeatedly been stressed by the health and development communities (UNDP 1999; Global Forum for Health Research 2004; Chirac and Torreele; 2006). While the Challenges lack of an explicit mandate to consider the broader SDH context in which technological advances are made available, they reinforce a separation between basic health knowledge and applied health services delivery.

A second criticism is that the initiative, financed almost entirely by private wealth, raises accountability, responsiveness, equity and representational issues. Even before the recent windfall to the Foundation from Warren Buffet, Kickbusch and Payne (2004, p. 11) describe it as "a scandal of global health governance that WHO member states…would allow a situation to arise in which a private philanthropy, the

8 Foundation for the National Institutes of Health. http://www.fnih.org/aboutus/aboutus.shtml (accessed September 9. 2006)

9 For summaries of the projects see http://www.gcgh.org/sitemap.aspx?SecID=300 (accessed September 9, 2006).

10 Grand Challenges in Global Health. http://www.icgeb.trieste.it/GENERAL/IntResGrant.htm (accessed September 9, 2006)

11 Neglected diseases, or diseases of the poor, are defined by Caines (2004) as those which principally affect poor people in poor countries for which health interventions, and research and development, are seen as inadequate to the need.

Table 1: The 14 Grand Challenges for Global Health

Goal	Grand Challenge
To improve childhood vaccines	1. Create effective single-dose vaccines that can be used soon after birth
	2. Prepare vaccines that do not require refrigeration
	3. Develop needle-free delivery systems for vaccines
To create new vaccines	4. Devise reliable tests in model systems to evaluate live attenuated vaccines
	5. Solve how to design antigens for effective, protective immunity
	6. Learn which immunological responses provide protective immunity
To control insects that transmit agents of disease	7. Develop a genetic strategy to deplete or incapacitate a disease-transmitting insect population
	8. Develop a chemical strategy to deplete or incapacitate a disease-transmitting insect population
To improve nutrition to promote health	9. Create a full range of optimal bio-available nutrients in a single staple plant species
To improve drug treatment of infectious diseases	10. Discover drugs and delivery systems that minimize the likelihood of drug-resistant microorganisms
To cure latent and chronic infections	11. Create therapies that can cure latent infections
	12. Create immunological methods that can cure chronic infections
To measure disease and health status accurately and economically in poor countries	13. Develop technologies that permit quantitative assessment of population health status
	14. Develop technologies that allow assessment of individuals for multiple conditions or pathogens at point-of-care

Gates Foundation, has more money to spend on global health than the regular budget of their own organization." In part the problem arises from the multiplication of initiatives which they argue balkanize global public health. However, it also represents a shift of the locus of priority setting away from governments that are, in more and more countries, at least minimally accountable to their citizens. This is not a process distinctive to the Grand Challenges initiative, but a common characteristic of many GPPPs.

Table 2: Alternative grand challenges for global health

Panel 2: Alternative Grand Challenges

Goal: To improve human health by addressing inherently global issues

GC#1: Develop international systems for fair trade and fair commodity pricing; support democratic mechanisms for human rights and redistribution of entitlements to peace and stability; and create incentives for redistributional social welfare efforts including humane employment and living wages, workplace safety, healthy housing and neighbourhoods, education and leisure needs, and safe environments

Goal: To foster "best practices" models of integrated political, social, and medical means of reducing social inequalities in health

GC#2: Learn from developing societies that have achieved substantial and sustained health improvements across social groups by studying what combinations, implementation processes, triggers, enabling aspects, and timing of political, social, economic, public health, and medical factors have been effective and achievable over the long term

Goal: To improve nutrition to promote health

GC#3: Create a system of food subsidies and income supports, analogous in size to the farm subsidies provided in industrialised countries, that would prevent poverty-induced malnutrition; work with local farmers, nutrition specialists, and agricultural scientists to develop methods of crop rotation and inter-cropping and other locally based approaches to improve the range and output of farming products for domestic consumption

Source: Reprinted from The Lancet, 366, Birn AE, Gate's grandest challenge: transcending technology as public health ideology, 514-519, Copyright 2005, with permission from Elsevier.

The lesson learned from this case study is that the relative scale of private philanthropy today is increasingly allowing such organisations to set the global health policy agenda. This includes, not only what interventions are supported, but also the research agenda which shapes available interventions. Given current priorities identified by leading philanthropic organisations, an over reliance on such funding risks a singularly technology-driven, biomedically-centred approach, rather than one that simultaneously supports policies and new knowledge that more effectively deals with equity and the SDH. In particular, the prominence given to philanthropic global health research funding risks obscuring the important political discourse on globalization's impacts on the SDH, and how to minimize health inequities arising from these impacts.

2.2 Health-focused global institutions and the SDH

There is a range of institutions at the global level whose mandates are ostensibly focused on health-related issues. Historically the World Health Organization (WHO) has played a lead role as the UN specialized agency for health since its creation in 1948 (see 2.2.1). Other UN organizations subsequently established have included health issues as part of broader mandates concerning children (UNICEF), agriculture/food (WFP, FAO, IFAD), population (UNFPA), and development (UNDP). Through these mandates, themselves the subjects of debate over how narrowly or broadly they should be, specific initiatives have been relevant to the SDH. Examples include UNICEF's campaign on child poverty (UNICEF 2005), UNDP's work on global trade (Malhotra 2002), and UNFPA's promotion of gender equality (Microcredit Summit Campaign/UNFPA 2005). In addition, UNICEF examined the health effects of structural adjustment programs and globalization during the 1980s (Cornia et al. 1987). The ILO Programme on Safety and Health at Work and the Environment, and its activities concerning social security and health insurance[12], are relevant here, as was its facilitation of the World Commission on the Social Dimension of Globalization (2004). Hsiao and Heller (2007) have produced a primer that aims to provide IMF macroeconomists with the essential information they need to address issues concerning health sector policy, particularly when they have significant macroeconomic implications. They write that such issues can also affect equity and growth, and are fundamental to any strategy of poverty reduction.

In general, a brief review of these initiatives suggest that, while the SDH are recognized as important, the solutions put forth have focused on selected health care interventions to alleviate health consequences, rather than measures to address the multiple pathways by which social conditions influence health outcomes.[13] The WHO Commission on Macroeconomics and Health, for example, undertook substantial work to demonstrate the importance of health to economic growth as a basis for increasing financing for health development (WHO 2002). However, the commission gave little attention to analysing the impact of macroeconomic policies on health. This suggests a tendency for health-focused institutions to propose solutions and actions that fall within specific, often biomedically-inscribed mandates, rather than recommendations more dependent on activities of other organizations. This tendency may be understandable from an institutional perspective, in terms of focusing activities and avoiding "mandate creep" (Koivusalo 2003), but hinders the production of an evidentiary base and policy recommendations for addressing the SDH.

Beyond the UN system a variety of health-focused initiatives have joined the global governance scene, varying in the degree to which they seek to address the SDH. Many of the GPPPs formed since the mid 1990s, such as GAVI and GFATM, are disease-focused (Buse and Walt 2000). As another example, GAIN is focused on nutrition, notably vitamin and mineral supplementation. As new initiatives, they have attracted public attention to specific causes, such as the need for certain technologies (e.g. vaccines, supplements), the neglect of specific diseases, gaps in global health research (Global Forum for Health Research, see 2.2.2) or the plight of certain populations. The limited analyses of GPPPs to date have raised concerns about their vertical (disease-focused) approach, longer-term sustainability, undermining of local health systems, capacity to achieve measurable results, and contribution to fragmenting global health governance.[14] Critical reflection on the good governance of GPPPs continues to be outpaced by their creation and operation.

Overall health-focused organizations in global governance have in principle the goal of affecting health processes and outcomes as their core mandates. Traditionally such organizations are closely linked to health care systems and may be focused on prevention, control and treatment of diseases. However, beyond a

12 For example, the GTZ-ILO-WHO-Consortium on Social Health Protection in Developing Countries aims to address the problem of poor access to health services and catastrophic health expenditures through the creation of sustainable systems of social protection in health.

13 By this we mean the pathways identified in the background paper by Solar and Irwin (2005, revised 2006), i.e. social stratification, risk exposure, vulnerability, and differential access to services.

14 See Hanefield J., Spicer N., Brugha R., Walt G. (2007), "How have global health initiatives impacted on health equity?" Health Systems Knowledge Network, WHO Commission on the Social Determinants of Health.

disease-based orientation, some health-focused organizations have tried to influence the SDH through advocacy and multi-sectoral activities. Collectively there are clear tensions within and across organizations on what should be the priorities in health development and how they should best be achieved. In general, attention to the SDH has increased somewhat within some organizations but remains challenged by a continued emphasis on biomedical and vertical approaches to health.

2.2.1 Case study: World Health Organization

WHO was created in 1948 as the UN specialized agency for health. It is one of a family of organizations formed to address functional areas of international concern, such as food and agriculture, labour and education. UN organizations concerned with economic and social work are coordinated by the Economic and Social Council (ECOSOC)[15] under the overall authority of the UN General Assembly. WHO itself was formed from a number of pre-existing regional health organizations, as well as the largely defunct Health Organization of the League of Nations and Office International d'Hygiène Publique. Its formation also came from a long history of international health cooperation dating from the 19th century.

The WHO's governance structure reflects this institutional history, as well as the need to reconcile the diverse interests of its 192 member states with the goals of protecting and promoting health worldwide. The World Health Assembly (WHA) is the plenary and legislative body of WHO, held each year in May to allow representation by all member states. Decision-making is governed by the one-member, one-vote rule, although decisions are largely taken by consensus rather than vote. The Executive Board (EB) is the executive that oversees the implementation of decisions taken by the WHA. Importantly, while EB member states are appointed by the WHA, following nomination by six regional committees, individuals serving in the it are expected to serve in a personal capacity as "technically qualified in the field of health" rather than as representatives of particular governments. EB members serve three year terms, and each year one-third of members are retired. Initially consisting of 18 members, by 2007 the EB had grown to 32. It meets twice annually, in January and after the WHA.

Headed by the Director-General, WHO's Secretariat is the administrative and technical organ, responsible for implementing the organization's activities. It consists of a headquarters in Geneva, six regional offices and country offices in selected member states. The regional offices are unique within the UN system in terms of their independence and decision-making powers, due to the prior existence of certain regional bodies (e.g. Pan American Health Organization) and to the belief that a decentralized structure was needed to effectively carry out WHO's work. In practice the appropriate balance among headquarters, regional and country level activities has been the subject of ongoing debate (Lee 1998).

The WHO Constitution (1948) provides the organization with a variety of instruments for directing and coordinating international cooperation ranging from binding treaties and conventions to agreed regulations, standards and recommendations. To date WHO has only once exercised its strongest legal authority, a binding treaty, in the form of the FCTC. Also the revision of the International Health Regulations (IHR) in 2005, which enter into force in 2007, strengthens WHO's legal standing on infectious disease control. However, as Fidler (2005b) notes, international laws and regulations concerning public health have largely developed outside the auspices of WHO in recent years, notably within multilateral trade agreements (see 3.3.3).

During its initial years, WHO pursued a largely disease-focused work program, with its staff overwhelmingly trained in the biomedical sciences. By the late 1960s the limitations of such an approach became evident with the failure of the malaria eradication program (Walt 1993; Siddiqi 1995). The Health for All (HFA) strategy and Alma Ata conference on primary health care sought to shift emphasis from a vertical (disease-focused) to horizontal (systems-based) approach. While a valuable advocacy tool for addressing the broad determinants of health, this approach faced

[15] ECOSOC has 54 members, elected by the General Assembly for three-year terms. It meets throughout the year and holds a major session in July, during which a high-level meeting of Ministers discusses major economic, social and humanitarian issues.

operational challenges in implementation (Irwin and Scali 2005). Further attention to the broad determinants of health came with the first International Conference on Health Promotion in 1986, and held every four years since (Kickbusch 2003; Koivusalo et al. 2006).

The ongoing tension between the vertical and horizontal approaches (Lee 2004) was also evident in efforts to tackle the HIV/AIDS pandemic. In 1986 WHO became the first international organization to concertedly address HIV/AIDS, and its approach was initially heavily biomedical. The creation of the Joint UN Programme on HIV/AIDS (UNAIDS) in 1994 followed in the wake of disagreement within WHO, and between WHO and other UN organizations, on whether the disease should be framed as a biomedical or development issue. UNAIDS was based on the latter approach, and encompassed concerns about human rights, equity and social justice. By the end of the 1990s HIV/AIDS had gained prominence as a health, development and even security issue (Feldbaum et al., 2006), and began to be discussed in an even wider range of forums including the UN Security Council, G8 and World Economic Forum (WEF). Ironically, despite broader attention, recent global disease initiatives are characterized by a focus on biomedical interventions (e.g. the 3 by 5 initiative) and a shift away from broader development goals (Koivusalo and Ollila 2001; Ollila 2005). Despite recognition of the need for more diverse expertise, notably in economics and other social sciences, WHO staff remain heavily biomedical in expertise (Peabody 1995; Siddiqi 1995; Ruger and Yach 2005). Again we emphasize that these approaches are not dichotomies, but the present disease- and treatment-specific focuses risk a less balanced approach to ensuring equity in health outcomes.

A study by the One World Trust concluded that intergovernmental organizations, like WHO, can face demands from different stakeholder groups and are judged against potentially conflicting measures of accountability. These include: "whether they serve the interests of their member states; whether they serve the purposes for which they were established; and how their impact compares to evolving standards of benefits and harms" (Blagescu and Lloyd 2006, p. 18). In principle, WHO is accountable to all its member states through the WHA and EB. In practice, due to their greater resources and thus capacity to contribute extra-budgetary funds for named activities or staff, industrialized countries exert far more influence, shaping the organization's work program, resource allocation, decision-making procedures and staffing (Vaughan et al. 1995; Shiffman 2006; Lee and Buse 2006). Where WHO has challenged powerful economic interests in such countries, such as the sugar and tobacco industries (Zeltner et al. 2000; Elperin 2003), the organization has faced reduced funding or risked becoming sidelined by alternative forums created by major donor countries (Kapp 2001; Boseley 2003; Simon 2005). The need for WHO to address organizational shortfalls has been acknowledged, but can also be used to disguise political pressures exerted by major donors seeking to protect their interests.

The lesson learned from this case study is that if multilateral organizations, particularly but not exclusively WHO, are to be effective policy 'knowledge banks' for actions on the SDH, core funding support for their activities must be separated from the pressures of donor countries.[16] *This applies particularly in the case of the SDH, which are intersectoral as well as intergovernmental, and thus more prone to conflicting stakeholder pressures. Organizations must also have the appropriate "skills mix" to tackle the SDH which, at present, they largely lack given a continued focus on biomedical staff.*

2.2.2 Case study: Global Forum for Health Research

In 1990 the Commission on Health Research for Development estimated that less than 10 per cent of the world's health resources were being applied to 90 per cent of the world's health problems. While it is not possible to make such an estimate today, the expression "10/90 gap" has passed into popular use as shorthand for the global inequalities in health research, and as a rallying call for more attention to the neglected areas of health research. The Global Forum for Health Research (GFHR) was founded in 1998 to promote research funding into neglected diseases and conditions that comprise the major burden of disease

[16] The issue of pressures from donor countries is dealt with in a separate paper, see Taylor, S., (2007) "Aid and Health," Discussion Paper, Globalization Knowledge Network, WHO Commission on the Social Determinants of Health .

in developing countries. Its activities include tracking resources at global and national levels, priority setting and capacity building for health research and the identification of research agendas. As well as producing a range of annual and biennial publications that highlight progress and advocate for the closure of gaps in health research for development, it also convenes an annual conference. Forum 10, held in Cairo, took place in November 2006 on the theme "Combating Disease and Promoting Health."

Registered as a Swiss foundation, the GFHR represents a new form of global governance: it is a stakeholder or partner organization and not a member organization. Its governing body, the Foundation Council, comprises a cross-section of governments, multilateral and bilateral agencies, foundations, policy makers and research institution leaders from developing countries, the private sector, civil society organizations and media. Informally the GFHR encourages collaboration across a wider spectrum of research groups and agencies, individual researchers and NGOs. Accountability and transparency in decision-making at the GFHR is affected through regular meetings of the Foundation Council (twice yearly) and the Council's Strategic and Technical Advisory Committee (three times yearly). Together they review and approve all activities of the organization; and publication of its biennial '10/90 Report on Health Research' and other publications that report on its activities relative to its goals. The GFHR's website provides details of the Foundation Council membership, as well as access to all its publications. Financial support for the GFHR's secretariat in 2005 was provided by the Rockefeller Foundation, WHO, the World Bank and the governments of Canada, Denmark, Ireland, Mexico, Norway, Sweden and Switzerland.

The GFHR web-site identifies health research broadly, encompassing: "biomedical research into new drugs, vaccines and diagnostics; to health systems and policy research which ensures that health systems are better informed and managed, to social science and operational research to improve access and uptake and to help us better understand what affects the health and the choices of people in the community".[17] The social determinants of health are not explicit in this list, but are implied. The metaphor of the '10/90' gap, however, directs attention primarily to disease-specific interventions, those health system requirements necessary for efficient delivery and those facets of social life that might predict efficacy and effectiveness. These concerns have also been reflected in the majority of papers and posters presented at the annual forums, although each year there appears to be more plenary and session topics addressing the broader social determinants.[18] The first formal external evaluation of the GFHR's activities was undertaken in 2000-2001 and the second external evaluation was completed in 2006. The GFHR's most visible indicator of success lay in its tracking of resource flows for health research.

The lesson learned from this case study is that, while a speculative inference only, the trajectory of the GFHR's agenda from a primary focus on diseases and medical interventions, into a more pluralistic concern with the SDH reflects that of many international health organizations. This is due, in part, to the increasing presence and organization of global health researchers/activists who have supported a broader SDH agenda.

2.3 Non health-focused global institutions and the SDH

Non health-focused institutions are concerned with a wide range of issue-areas that indirectly affect the SDH. These institutions may address specific health issues, as part of their mandates concerning, for example, trade and investment, education, housing, or employment. They also influence the SDH through the pursuit of these core mandates. The most important non health-related institutions in global governance, in terms of impacts on the SDH, are those concerned with governance of the world economy. These are led by the IFIs (see 2.3.1) and WTO, and their regional counterparts, along with the OECD and G8 (see 2.3.2).

[17] FAQ, http://www.globalforumhealth.org/Site/001__Who%20we%20are/004__FAQs.php (accessed September 22, 2006)

[18] This assessment is based on one of the authors' (RL) participation in the past three Forums, a cursory examination of the titles of forum presentations, and comments made by several delegates to the author during Forum 9. The 2005 publication, Global Forum Update on Research for Health, Volume 2: Poverty, Equity and Health Research also presented, as its title indicates, a number of articles on global research, social determinants of health, and vulnerable populations.

The manner in which the SDH is influenced by non health-based institutions is dependent on a number of factors. First, there appears to be no or minimal legal obligations for these institutions to consider health and its broad determinants. The development of international human rights law could inform a strengthening of global governance for the SDH (see 3.6.2), although human rights treaties are binding on states parties and not on multilateral institutions per se. It may be argued that human rights instruments impose obligations on global institutions indirectly by way of obligations binding the member states of these institutions to citizens' rights in their own and in other countries (Hunt 2005d; Hunt 2006b). This argument has been advanced with respect to the WTO and its member states. However, Fidler (2005a) notes that international trade law, including aspects directly related to health, is more developed than international health law. He points to the problematic revision of the International Health Regulations (IHR), a slow and delayed process until its eventual agreement in 2005. Unlike most international obligations including human rights treaties, WTO agreements are also backed by sanctions, so there is a risk that the agreements will be given greater weight in the policy decisions of national governments. Furthermore, trade relations are often asymmetrical in that they take place between more and less economically powerful countries, and sanctions that may arise from them therefore have inequitable consequences across countries (Birdsall 2006; Stiglitz and Charlton 2004).

Second, to what extent are health objectives compatible with their mandates and declared goals? Available analyses suggest that there are some measures to protect health within certain multilateral trade agreements (MTAs), such as the clarifications provided by the Doha Declaration and Paragraph 6 decision for the TRIPS agreement (Bloche 2002). The asbestos dispute between the EU and Canada also suggests there are flexibilities for health protection (Ranson et al. 2002; Koivusalo 2003). However, the scope for applying these flexibilities may depend on how such key concepts as "public health emergency", "least trade restrictive" and "sufficient scientific evidence" are interpreted (Woodward 2005). The beef hormone dispute between the EU and US suggest stringent interpretation of the standard of scientific evidence needed to uphold a ban (see also Box 2: SPS and the EU ban on hormone-treated beef). Similar concerns are raised by the WTO decision on the case brought by the US, Canada and Argentina ruling against stringent EU regulation of GMOs. Moreover, there remains limited analysis of the health protection available under the growing number of regional and bilateral trade agreements in force which create so-called WTO-plus measures.[19]

Limited attention has been given to the impact of MTAs on the SDH. For example, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) has been the subject of controversy because of its impact on access to medicines.[20] Drugs protected by patent are sold at higher prices, making them less affordable to the poor, thus contributing to health inequalities. Despite official claims that efforts have been made to resolve the sometimes competing objectives of trade liberalization and health development through the Doha Declaration and Paragraph 6 decision, the relevance of these provisions remains limited. Furthermore, concerns remain over the focus, narrowness and applicability of the Paragraph 6 decision. This is further complicated by the shift to regional and bilateral trade agreements which give health objectives even less protection under so-called TRIPS-plus measures.

Alongside trade agreements, it is important to note the role of standards-setting bodies and, in particular, the degree to which efforts to tackle the SDH are represented within them. One example is the Codex Alimentarius Commission (or Codex), a joint body created by WHO and FAO in 1963 "to develop food standards, guidelines and related texts such as codes of practice".[21] In 1995, as part of the Uruguay Round of trade negotiations under the General Agreement on Tariffs and Trade (GATT), the Codex was changed to a binding regulatory body which elevated its status as a standards setting body. On the one hand, critics argue that the excessive and dominant role of large-scale

19 See Blouin C., Bhushan A., Murphy S., Warren B. (2007), "Trade liberalisation," Discussion Paper, Globalization Knowledge Network, WHO Commission on the Social Determinants of Health.

20 See Correa C. (2007), "Intellectual Property Rights and Inequalities in Health Outcomes," Discussion Paper, Globalization Knowledge Network, WHO Commission on the Social Determinants of Health.

21 See http://www.codexalimentarius.net/web/index_en.jsp.

commercial producers has led to the setting of standards too low to adequately protect consumers. Alternatively, there may be an incentive to set standards at a high enough level that they can meet (by virtue of the scale of their operations, access to capital and technology, etc.) but higher than small producers can meet, thus bolstering their competitive position and posing economic risks for small-scale producers which would struggle to meet them. A key point this raises is that optimizing the health effects of trade (or other international) policies requires a holistic view, taking into account both direct (biomedical) and indirect (SDH) health effects. A purely economic view in favour of deregulation will result in standards that are too low. A purely biomedical view may set them too high. This represents a strong case for raising the profile of SDH relative to both, and of institutionalizing this in the global governance system, especially where it applies to bilateral, regional and global trade rules.

A more promising link with the SDH is the inclusion of health issues within broader development initiatives. At the World Summit for Social Development (see 2.3.1) in 1995, governments reached consensus on "the need to put people at the centre of development." The Copenhagen Declaration adopted 10 commitments central to the SDH, including poverty reduction, full employment and social integration. These commitments have been reaffirmed at two follow up meetings held in 2000 and 2005, although many remain concerned as to the true political priority given to fulfilling them. These commitments have been largely subsumed by the health goals included within the Millennium Development Goals (MDGs), intended as a framework for targeting development assistance in key priorities (see 2.3.2). The MDGs provide a potential, so far unproven, tool for addressing the SDH, with three of its goals explicitly addressing health, and an additional four goals related to the broader social determinants of health.

Third, to what extent are there a sound evidence base and the potential for feasible action linking a non-health policy domain with the SDH? Over the past decade there have been mostly unheeded efforts to draw attention to the social impacts of globalization, including health. For example, the ILO established the World Commission on the Social Dimension of Globalization (see 2.3.3) whose final report, *A Fair Globalization: Creating Opportunities for All* is "an attempt to help break the current impasse by focusing on the concerns and aspirations of people and on the ways to better harness the potential of globalization itself" (ILO 2004, p. ix). The vision put forth by the Commission is:

> a process of globalization with a strong social dimension based on universally shared values, and respect for human rights and individual dignity; one that is fair, inclusive, democratically governed and provides opportunities and tangible benefits for all countries and people (ILO 2004, p. ix).

The World Social Forum (WSF) also sought to challenge current forms of globalization (see 2.3.4). It is described as:

> an open meeting place for reflective thinking, democratic debate of ideas, formulation of proposals, free exchange of experiences and inter-linking for effective action, by groups and movements of civil society that are opposed to neo-liberalism and to domination of the world by capital and any form of imperialism, and are committed to building a society centred on the human person" (World Social Forum n.d.).

In addition, there is now a substantive body of empirical evidence analyzing the impact of globalization on such social consequences as poverty, labour market restructuring, income inequalities, physical environments, health systems, and financial flows (Pangestu 2001; Lee and Vivarelli 2006; Labonté and Schrecker in press a-c). Health has also been included in research and policy discussions based on the concept of global public goods.

2.3.1 Case study: The IMF and World Bank

The IMF and World Bank play a critical role in providing and catalyzing external financing for developing countries, and in the prevention and resolution of debt and financial crises, which have had major effects on SDH in recent decades.[22] Ad-

[22] See Taylor S. (2007), op.cit; and Rowson M. (2007) "Globalization, debt and poverty reduction strategies," Discussion Paper, Globalization Knowledge Network, WHO Commission on Social Determinants of Health.

ditionally the nature of their response to debt and financial crises, and the conditions attached to their loans, give them considerable influence over policy-making processes in many developing countries, over an extended period in the case of most low-income countries.

The Fund and Bank are also major sources and commissioners of research, the Bank having consciously established a role as a self-styled "Knowledge Bank" since 1996 (Cohen and Laporte 2004).[23] Combined with the considerable financial and human resources at their disposal, this gives them a major role in establishing the prevailing political and intellectual ethos of development. As a result, they have considerable influence over the evolution of key economic variables with major implications for the SDH, such as household incomes and poverty and the level and allocation of government expenditure, and over policies in sectors of critical importance to health such as health services and education. The nature of their roles in these areas, the way in which they carry them out, and the effectiveness with which they do so, are closely linked to their respective governance structures This confers on these institutions considerable importance as a driving force behind the evolution of the SDH in developing countries.

The IMF and World Bank's governance structures are characterized by a system in which countries' votes are weighted according to their economic strength. This means that decision-making is dominated by industrialized countries, which have around 60 per cent of the votes (compared with 16 per cent of world population), although the institutions' policies and activities impact overwhelmingly on developing countries. Accountability to the membership, particularly to developing countries and to civil society, is further undermined by a number of other factors, including:

- the constituency system (whereby eight countries have their own Executive Directors, while the remaining 16 Directors are "elected" by groups of between four and 24 member countries), and the inability of Directors representing constituencies to split their votes
- no formal obligation on Directors to reflect the views of the governments or interests of the countries they represent, and thus the absence of effective mechanisms for accountability
- the failure to make draft decisions or supporting documents publicly available until decisions have been approved
- the secrecy of Executive Board discussions
- the absence of formal votes in the Executive Board (where substantive discussions occur), so that the secrecy of Board discussions prevents those outside government from discovering how the Directors who represent them have (notionally) voted on behalf of the populations of the countries they represent
- inadequacy of the human resources available to developing country Directors relative to their workloads
- the de facto appointment of the heads of the institutions by the US government (in the case of the World Bank) and the members of the European Union (in the case of the IMF).

The overwhelming dominance of high-income country governments in IMF and World Bank decision-making – including over how changes to their governance systems, voting weights, and other procedural rules are made – also represents a fundamental obstacle to reform.

These governance structures, characterized by what Chowla et al. (2007) describe as a "democratic deficit", inevitably shape the policy decisions taken by the IMF and World Bank, and thus the nature and emphasis of their activities (Pincus and Winters 2002). A number of the major activities of these institutions have been widely criticized as having had substantial adverse effects on health and its social determinants. These include their management of debt and financial crises over the past three decades, their promotion of

[23] The scientific credibility of some of that knowledge, however, has been called into question in a recent independent evaluation of its research. Some of the most critical comments were applied to World Bank studies linking globalization/trade openness to growth and poverty reduction.

"structural adjustment" policies (particularly in Sub-Saharan Africa and Latin America), their role in the transition process in Eastern Europe and Central Asia, and the nature of health policy reforms promoted by the World Bank. Given recognition of the important link between the governance of the World Bank and IMF, and the effectiveness of their policies, there is some evidence of efforts to make them more externally accountable through different ex post evaluation processes. However, to date accountability has been focused on northern NGOs and institutions, raising questions about their effectiveness if powerful northern interests are directly affected. It is also important to acknowledge shifts in policy thinking within the World Bank under the leadership of James Wolfensohn (1995-2005) who gave greater emphasis to poverty reduction and equity (Wolfensohn 2005). It remains unclear whether this agenda will continue under the leadership of Robert Zoellick who replaced the briefly serving Paul Wolfowitz in 2007.[25] Finally, there is some degree of plurality in the types of knowledge generated by the World Bank, although it is unclear how this is supported internally in terms of career mobility. The assessment by Banerjee et al. (2006) of World Bank analyses questions their quality, notably studies of globalization, trade liberalization and growth, and their ideological rather than empirical focus.

The lesson learned from this case study is that the governance of the World Bank and IMF falls far short of recognized principles of good governance. This feature continues to be heavily criticized by a wide range of stakeholders. This, combined with substantial evidence of the adverse impacts caused by the policies of these institutions on the poor and vulnerable within and across societies, suggests that fundamental changes to the governance of the World Bank and IMF is needed to effectively tackle the SDH. WHO could take a lead role in drawing attention to the links between the weak governance of these organizations, and their resultant adverse effects on the SDH.

2.3.2 Case study: The World Summit on Social Development

Held in Copenhagen in 1995, the World Summit for Social Development was the largest ever gathering of world leaders at that time. It pledged to make the conquest of poverty, the goal of full employment and the fostering of social integration overriding objectives of development. In June 2000 the meeting reconvened (Copenhagen+5) to review what had been achieved, and to agree to new initiatives. These commitments are all relevant to the SDH:

1. To eradicate absolute poverty by a target date to be set by each country
2. To support full employment as a basic policy goal
3. To promote social integration based on the enhancement and protection of all human rights
4. To achieve equality and equity between women and men
5. To accelerate the development of Africa and the least developed countries
6. To ensure that structural adjustment programmes include social development goals
7. To increase resources allocated to social development
8. To create economic, political, social, cultural and legal environment that will enable people to achieve social development
9. To attain universal and equitable access to education and primary health care and
10. To strengthen cooperation for social development throughout the UN.

The key UN body in charge of follow-up and implementation of the Copenhagen Declaration and Programme of Action is the UN Commission for Social Development, a functional commission of the Economic and Social Council (ECOSOC). Comprised of 46 elected members, the Commission meets annually in New York to consider a key social development theme. In 2006 the Commission reviewed the first UN Decade for the Eradication of Poverty (1997-2006) (UN Department of Social Affairs n.d.).

In principle the Commission's mandate means that it has the potential to affect many of the SDH. However, to achieve this requires stronger political support. NGOs expressed "profound disappointment" at the low priority given to Copenhagen+5 and "grave concern" at the lack of will to carry its commitments forward. Only 19 heads of state, mostly from Africa with only two from high-income countries (Denmark and Norway), attended the summit (Raghavan 2000a).

While the Commission's report, A Better World For All, was a joint publication with the World Bank, IMF and OECD of Copenhagen+5, donors failed to empower the UN, and ECOSOC in particular, to take a lead role on social development. Thus, despite three summits and an agenda for social development, follow up support for implementation of its goals has shifted to the Millennium Development Goals. The continued low priority given to the role of ECOSOC may hinder effective efforts to address the SDH, underscoring the importance of WHO taking the lead role in this area.

The lesson learned from this case study is that there has been broad-based global support for increased efforts to tackle the SDH, and the opportunity to effectively do so through recent initiatives such as the World Summit on Social Development. However, this requires donor governments and key global institutions to strengthen financially and support the UN to follow up the commitments already made.

2.3.3 Case study: Millennium Development Goals

The Millennium Development Goals (MDGs) are a set of eight time-bound (to 2015) and measurable goals and targets for combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. In September 2000 world leaders met to agree the UN Millennium Declaration (http://www.un.org/millennium/declaration/ares552e.pdf). This was followed by commitments of resources and actions based on the declaration at the International Conference on Financing for Development held in Monterrey, Mexico in 2002. The goals are intended to provide a framework for the entire UN system to work coherently towards a common end. As described by the UN, the MDGs are "a blueprint agreed to by all the world's countries and all the world's leading development institutions. They have galvanized unprecedented efforts to meet the needs of the world's poorest" (UN 2002).

The importance of the MDGs to global governance is that they represent framework for action by a wide range of international organizations, 190 governments and non-state actors. For example, the UN's Millennium Campaign (http://www.millenniumcampaign.org) has brought together civil society groups, faith-based organizations, trade unions and celebrities. The MDGs have also generated new funding and drawn renewed attention to key global health challenges (UN 2002).

However, the MDGs have not escaped criticism. With respect to global governance, the process by which they were adopted, the measure of their achievement, and their potential to skew development policy have been questioned (Attaran 2005). It is argued that the MDGs themselves, based on a declaration as a broad statement of principles and values, are selective, focused inappropriately on measurable targets, and defined within an arbitrary timeframe. This resulted from the need to turn a broad philosophical statement into a list of actions that are politically short-sighted and financially attractive. However, the result is the prioritization of certain goals, and the omission of others, such as acknowledgement of health as a human right, environmental protection and employment. For example, the MDG's goal to halve poverty (measured as less than US$1 per day) by 2015 contrasts with rights-based arguments which call for an adequate standard of health by all (Reddy and Pogge 2005), and even with the World Summit on Social Development's commitment to fully eradicate absolute poverty by a set date. Moreover, the MDGs focus on selected social sectors, notably education and health, rather than on the broader structure of the global political economy which impact on the SDH.

Of particular note is the lack of emphasis on equity (other than gender) from the MDGs despite the Declaration's references to social justice, principles of equality (rights and opportunities), and solidarity. The focus of the MDGs is on national aggregates, not on the equitable distribution of any gains achieved. Thus, one could halve poverty but still leave half a population worse off. Moser et al. (2005, p. 1,182), in their study of 22 low- and lower-middle-income countries, find that: "National improvements in under 5 mortality, in line with the millennium development goal, are as likely to be accompanied by increasing as decreasing inequalities in child mortality within countries; adding an equity dimension to this goal would give an impetus to adopting policies that tackle health inequalities". Development experts further argue that growth in income of the poor in real terms without

consideration of the share of growth captured by the poorest population groups cannot be described as pro-poor; and that redistribution of wealth to address global inequalities within and across countries must also be addressed (ODI 2006).

Finally, there is criticism of how change is defined and measured by the MDGs. There is a focus on selected technically defined targets and measurable indicators that are narrow in scope and do not incorporate targets or indicators associated with changes in the SDH (Reddy and Pogge 2005; Reddy and Heuty 2006). Consequently, the MDGs do not address the underlying and structural causes of the health problems and associated targets they identify. Further, Attaran (2005) argues that several of the MDG targets are either practically or inherently not amenable to measurement, making progress impossible to determine.

The lesson learned from this case study is that the MDGs are a demonstration of significant commitment by the international community to strengthening development efforts, but are centred on outcomes (goals) rather than processes. The goals set miss addressing the SDH because of their lack of emphasis on underlying political and economic causes of social stratification, risk, vulnerability and access that create inequities in health problems. These causes are partly recognized in the Millennium Declaration's reference to principles of social justice, equality and solidarity but these fundamental principles have not been followed through in the operationalization of these commitments in the targets set by the MDGs.

3.1 Assessing the challenges for good global governance to better address the SDH

This section reviews the available evidence assessing the good governance of key global governance institutions concerned with the SDH. Given the limitations of the current evidentiary base, this analysis can only serve as an indicative, rather than a comprehensive, discussion. Nonetheless, it demonstrates the importance of strengthening global governance both as one important means of tackling the SDH, and with specific reference to incorporating SDH concerns within existing, new or reformed global institutions.

3.2 Policy coherence and coordination

The problems of poor policy coherence and coordination in global cooperation have been long and widely recognized (CIDA 2002; OECD 2003). As described global governance is characterized by a proliferation of institutional actors as a result of greater interconnectedness across issue areas, and the involvement of non-state actors. Internally many institutions face increased fragmentation as they seek to incorporate a broader range of issues within their mandates. Across institutions this has led to "mandate creep" and potential overlap with other institutions (Lee et al. 1996).

Efforts to increase coordination and coherence have been hindered, in the first instance, by a lack of, or inequities in, representation and accountability in many of the global institutions. It is further constrained by the absence of any overarching authority in global governance above sovereign states. Key institutional actors concerned with global governance operate largely independently of one another, formally accountable to certain constituencies such as the most powerful member states, but not to a higher level of authority. Importantly the increased number of institutions, and scope of their work, reflect differences in perspectives as how best to tackle global issues. There are fundamental differences in goals, expertise, value bases, constituencies and resources among institutions. Moreover, these diverse institutions vary in the power and influence they exert. Dissatisfaction among some donor governments with certain institutional mechanisms (including WHO's) has led to the

creation of alternative institutions, adding further to the coordination challenge.

What priority is given to the SDH, and how policy problems and solutions are framed, is currently shaped by those institutions that hold power and influence. WHO currently is not one of them. For example, in analysing how equity and social inequalities can be addressed more effectively in a globalizing world, Deacon (2004) observes fragmentation and competition among the World Bank, WTO, the UN system, the G8 and other groupings of countries, and national social development initiatives. The current global architecture is, in short, a complex array of independent, unequal and even competing, institutions.

Within the health sector, the need for better coordination is recognized as a long-standing challenge. There is substantial evidence of the imperfections of the global governance architecture in the form of duplication of effort, overlapping mandates, gaps in effort, and undue transaction costs imposed on recipient countries (Lee et al. 1996; Buse and Walt 1997; Walt et al. 1999a; van Diesen and Walker 1999; Martinez 2006). The WHO Constitution states that one of its functions is "to act as the directing and co-ordinating authority on international health work" (Paragraph 2(a)). However, dissatisfaction by some donor governments with certain WHO activities from the late 1970s deemed "political", notably "health for all", essential drugs and regulation of breastmilk substitutes, led to the creation of alternative mechanisms outside WHO. This included UNAIDS,[25] the Global Alliance for Vaccines and Immunization (Muraskin 2002) and Global Fund to Fight AIDS, Tuberculosis and Malaria (Phillips 2002).

The perceived need for improved policy coherence has arisen more recently from efforts to address key health issues through action in cooperation with other sectors. Globalization has blurred policy domains by creating greater linkages across issue areas, as well as levels of governance. According to the UK Department for International Development (UK DFID 2006), policy coherence "is achieved when policies across a range of issues (for example trade, migration, security) support, or at least do not undermine, the attainment of development objectives." Similarly the OECD (2003, p. 2) defines policy coherence as "systematic promotion of mutually reinforcing policy actions among government departments and agencies creating synergies towards achieving the agreed objectives." The lack of policy coherence, according to UK DFID (2006) weakens the efficiency and impact of aid. This occurs through:

- lost opportunities for complementarities when policies contradict each other
- too few mechanisms to systematically detect and resolve policy conflicts, and the difficulty of balancing legitimate domestic and global interests when such conflicts become apparent
- insufficient political pressure for change, both at the domestic level (with limited public awareness on the impact of different policies and trade-offs made by government) and internationally (with limited forums for low income countries to hold rich ones to account)
- complex decision-making systems where multiple domestic interests compete alongside multilateral agendas, special interest groups and developing partners.

There have been ongoing efforts since the early 1990s to improve coherence and coordination in health development as part of a "new architecture of aid". For example, within individual countries, the sector-wide approach (SWAp) has been adopted to bring together institutions concerned with health development. SWAp is defined as:

> a process in which funding for the sector – whether internal or from donors – supports a single policy and expenditure programme, under government leadership, and adopting common approaches across the sector. It is generally accompanied by efforts to strengthen government procedures for disbursement and accountability. A SWAp should ideally involve broad stakeholder consultation in the design of a coherent sector programme at micro, meso and macro levels, and strong co-ordination among donors and between donors and government. (UK DFID 2001, p. 1)

[25] See Hanefield J., et al., op.cit.

While focused on the health sector per se, and thus not an instrument for addressing the SDH, SWAp offers ideas for strengthening institutional links across multiple sectors. Other UN initiatives include the Common Country Assessment (CCA), UN Development Assistance Framework (UNDAF), and UN Resident Coordinators. Joint efforts by WHO and the ILO on ensuring decent working conditions in the Americas illustrates the potential for strategic and operational collaboration (ILO 2006).

Another approach is to strengthen coordination of institutions across a specific health issue. The Integrated Management of Childhood Illness (IMCI) is an approach by WHO and UNICEF that focuses on promoting and protecting the well-being of the whole child. Children brought for medical treatment in the developing world often suffer from more than one condition, making a single diagnosis impossible. IMCI is an integrated strategy which takes account of the variety of factors that put children at serious risk. It ensures the combined treatment of the major childhood illnesses, emphasizing prevention of disease through immunization and improved nutrition (WHO 1999).

In relation to the SDH, based on national-level observations, it is widely acknowledged that impacts on health and health determinants arise from policies dealing primarily with matters other than health (Ståhl et al. 2006). This is especially important in areas where health impacts have not traditionally been considered, such as economic, trade and industrial policies. Furthermore, by definition, efforts to address the broad determinants of health including the SDH require engagement with non-health sectors. Greater engagement across global institutions working in different sectors is thus dependent on current efforts to redress the shortfalls in coordination and coherence. The most prominent of these initiatives is the MDGs. Similarly the Poverty Reduction Strategy (PRS) approach emphasizes cross-sectoral collaboration to (a) identify effective strategies to reduce poverty; and (b) to modify external partnerships and assistance to reduce poverty more effectively (World Bank 2006). Who identifies effective strategies remains a contentious issue.

While it is beyond the scope of this paper to review the range of measures adopted to improve coordination and coherence, a number of observations can be made about efforts to date:

- Although strong consensus exists for such improvements, the effectiveness of such efforts remains dependent on the degree to which powerful interests are willing to submit to coordination efforts. There has been a tendency for such interests to create new institutional mechanisms where they retain their dominance, rather than redistribute power among a wider range of stakeholders within existing mechanisms. For example, the US government decision to establish PEPFAR rather than contribute to the Global Fund or UNAIDS has resulted in additional, even competing, institutional structures.[26]
- Health appears to be well recognized in broader development initiatives. However, policy coherence is hindered by the uneven level of development of global governance across different sectors. Economic globalization has led to strengthened regulation of trade and finance given their importance to high-income countries and corporate interests. At the same time health-based normative and standard-setting work has not developed to the same degree and speed (Fidler 2005b).
- There is a clear tension between the need to accommodate diverse ideological perspectives on health development, through a plurality of institutions, and the optimal use of limited resources through coordinated action. How can the SDH be served best?
- There remains need at the global level for a central body to act as a key reference point, for example, to consolidate technical knowledge, monitor global trends in health, and serve as a venue for policy debate, especially putting the SDH at centre stage. This presents an important and challenging opportunity for WHO.
- Comparative assessment of the effectiveness of various initiatives to improve coordination and coherence remains needed. The proliferation

26 See Hanefield J., et al., op.cit.

of new coordinating mechanisms, particularly disease-focused initiatives, has outpaced critical evaluation of them.
- The nature of contemporary global governance relevant to the SDH cannot be described as a "system" per se. Rather it is a set of institutions evolving from a base established in the 1940s, through ad hoc changes determined by historical precedent, an ideological orientation and importantly the current and historical unequal distribution of power and resources. As a result, existing institutions are neither an expression of the collective will of the global community, nor a beneficiary-centred strategic approach to addressing common needs.

3.3 Transparency and accountability

Mechanisms of transparency and accountability in public policy are fundamental to the effective functioning of democratic political systems. At the national level, such mechanisms include processes of appointing political representatives, provisions for accessing information, opportunities to influence policy discussions, and systems for challenging the actions of public authorities. At the global level, where constituencies may be dispersed or unclear, and there is an absence of overarching and binding authority, effective mechanisms are a significant challenge are clearly not in place.

There has been increased attention to improving the transparency and accountability of global institutions in recent years. For example, the IFIs Transparency Resource has developed 250 indicators for assessing transparency from their perspective within the international financial institutions.[27] Similarly the One World Trust (Blagescu et al. 2006) has developed a Global Accountability Index to individually assess "thirty of the world's most powerful organisations from the corporate, inter-governmental, and non-governmental sectors" including WHO, the World Bank, Nestlé, Pfizer and the International Federation of Red Cross and Red Crescent Societies (IFRC). It defines accountability as "the processes through which an organisation makes a commitment to respond to and balance the needs of stakeholders in its decision-making processes and activities, and delivers against this commitment," Four core accountability dimensions are identified as critical to managing accountability claims from both internal and external stakeholders: transparency, participation, evaluation and complaint and response mechanisms. The report concludes that global governance today is defined, not by unaccountable organizations, but by "organisations that are either accountable to the wrong set of stakeholders, or focus their accountability on one set of stakeholders at the expense of others" (Blagescu et al. 2005). The critical challenge is achieving an appropriate balance among a diverse range of stakeholders, both internal (individuals or groups formally part of the organization) and external (individuals or groups affected by an organization's decisions). Notably the report's findings are limited by assessing each organization individually, rather than comparatively, and according to criteria set by the organizations themselves rather than an objective set of standards for assessing performance.

Implicit or explicit assumptions of stakeholder accountability underpin recent efforts to engage with institutional actors within the state, the market and civil society in policy making. The result has been a proliferation of "partnerships" and global public policy networks (GPPNs) seen as a less formal participatory, yet more integrated, approach to global governance (Reinicke et al. 2000). In this context international organizations are cast in the role of convenors, platforms, networkers and, at times, part financiers of GPPNs. A good example is the work of the Global Public Policy Institute (GPPI), a non-profit think tank based in Berlin, whose work seeks to strengthen "strategic communities around pressing policy challenges by bringing together the public sector, civil society and business."[28] In global health, examples include the Healthy Cities Networks, Global Network of People Living with HIV/AIDS, and Framework Convention Alliance.

Despite this apparent broadening of stakeholder involvement, a more systematic and critical assessment of the representativeness, quality of transparency and accountability remains needed for most global institutions concerned with the SDH. The focus to date has largely been on improving financial and program

[27] See http://www.ifitransparencyresource.org/en/index.aspx (accessed October 17, 2006).
[28] See www.gppi.net (accessed October 17, 2006).

accountability, notably to major funders of global initiatives, rather than to a broad range of stakeholders, especially beneficiaries. The current global governance architecture related to the SDH lacks agreed definitions and measures of transparency and accountability. What processes should be transparent? For what should an organization be accountable and to whom? Should a regulatory global agency be accountable to global stakeholders that it aims to regulate? To whom and for what are global CSOs, networks and corporations accountable, apart from the national laws that might regulate them, or the interests of their own members?

Among health-focused organizations, the Global Fund, corporate associations (e.g. International Federation of Pharmaceutical Manufacturers and Associations - IFPMA) and various global public-private partnerships remain largely outside wider public scrutiny. Large foundations such as the Gates Foundation operate independently given their substantial resources. Large transnational NGOs are answerable to boards of directors and funders, rather than to the communities they serve. Even intergovernmental organizations, led by WHO, must reflect on who their stakeholders are (beyond member states) and how they should engage with them. Perhaps most importantly there are questions to be raised about the narrow range of stakeholders served by key institutions such as the OECD and G8. Finally, in keeping with generally accepted principles of democracy and/or of good governance, an overall system of "checks and balances" must evolve. Its purpose would be to ensure collective transparency and accountability across the diverse institutions as a key feature of any system of global governance.

3.3.1 Case study: International Health Regulations

The International Health Regulations were established in the 19th century, known then as the International Sanitary Regulations, to govern sanitary conditions required by all forms of transport for preventing the spread of disease. The IHR agreement was ostensibly driven by the desire to facilitate growing trade relations (Fidler 2005a). Limited to a few selected diseases and functions, the IHR has been subject to periodic attempts at revision. Economic globalization, intensifying trade and incorporating almost the entire the world trading system, led to a fundamental review in the late 1990s. This proved an initially protracted process because of a lack of political will and resources to develop a new approach. The SARS outbreak and prospects of pandemic influenza, however, lent a greater sense of urgency to the process in high-income countries. The revised regulations were unanimously adopted on May 23, 2005 by the World Health Assembly, and are scheduled to come into force in June 2007.[29] The broadened purpose and scope of the IHR (2005) are to "prevent, protect against, control and provide a public health response to the international spread of disease and which avoid unnecessary interference with international traffic and trade".

The provisions adopted within the IHR (2005) are a good example of enhanced transparency and accountability for the purposes of global disease surveillance and control. The revised mandate it gives to member states and WHO has expanded their respective roles and responsibilities. In particular states parties to the IHR (2005) are required to develop, strengthen and maintain core surveillance and response capacities to detect, assess, notify and report public health events to WHO and respond to public health risks and public health emergencies. WHO, in turn, is to collaborate with states parties to evaluate their public health capacities, facilitate technical cooperation, logistical support and the mobilization of financial resources for building capacity in surveillance and response. States Parties and WHO are now developing plans for implementing IHR (2005).

Perhaps the most significant achievement of the revised IHR (2005) is its capacity to draw on a far wider range of information sources than member states. In the past a key limitation of surveillance, monitoring and reporting efforts was dependence on governmental sources of data which, if not forthcoming, could not be effectively challenged. The IHR (2005) states that, while national IHR Focal Points will liaise with WHO IHR Contact Points, WHO "may take into account reports from sources other than notifications or consultations and shall assess these reports

29 All Member States of WHO will become states parties to the IHR (2005) except for any that reject the Regulations before December 15, 2006. States not Members of WHO may become states parties to the IHR (2005) by notifying the Director-General of WHO of their acceptance.

according to established epidemiological principles and then communicate information on the event to the State Party in whose territory the event is allegedly occurring" (Article 9.1).

Given the origins of the IHR, there remain concerns about how the key term "public health emergency of international concern" will be interpreted in relation to the need to "avoid unnecessary interference with international traffic and trade." Should a public health risk arise requiring measures to restrict trade, how will application of the IHR differ from, for example, measures under the WTO to protect public health (see Section 3.3.3)? How will public health interests fare against trade interests should disagreement over "level of proof" of "scientific evidence" arise? The IHR (2005) remains unclear in this respect, leaving the protection of public health potentially secondary to powerful economic interests.

The lesson learned from this case study is that the key function of global disease surveillance, monitoring and reporting has been enhanced by increased transparency. This has taken the form of greater participation of non-state actors in what was hitherto dependent on government information sources. The increased availability of global information and communication systems provides an opportunity for improved information sharing, as well as the reduced capacity of governments to withhold important information from the global community. This reality has been institutionalized under the IHR, a function focused largely on disease control, yet raises important implications for enhancing transparency to support the SDH.

3.3.2 Case study: The Group of Eight countries

While global governance is ostensibly concerned with the collective management of common affairs across the global community, it is important to recognize the major influence of the Group of Eight countries. The G8 is an informal forum for the world's most economically powerful countries, collectively representing around 65 per cent of the world's GDP.[30] Its purpose is to provide a platform for bringing ministers of various portfolios together to discuss issues of mutual concern. Given the economic power of member states, however, how such issues are addressed does have implications for the wider global community. Moreover, the agendas of G8 meetings have increasingly addressed issues of global concern, such as infectious diseases, climate change, security and debt. In doing so, there are concerns that the G8 is inappropriately assuming a global governance role without, for example, sufficient accountability, transparency and representation.

In practice, the G8 is distinctive in its lack of "the two main characteristics of more structured international governmental organizations (IGOs): a constitutive intergovernmental agreement, and a secretariat" (Hajnal 2005). Some view the G8 as a forum "where heads of state and government take cooperation further than their officials and ministers can" (Bayne 2001, p. 23). As the G8 Research Group claims, "Despite widespread media scepticism…and continuing concerns about its legitimacy and representation, the G8 stands as the one system of international institutions providing effective political direction for our rapidly evolving world."[31] Others do not agree, arguing that the institution is important as a source of "group hegemony," a construct "that explains how a few wealthy countries, namely the G7, maintain the liberal economic order, and how the rules governing this order help perpetuate the disparity between rich and poor countries" (Bailin 2005, p. viii). Understanding its role is essential to understanding global health disparities. A critical issue here is that many policy choices made by the G8 – for example, about development assistance and debt relief – have their major impacts outside the G8, in countries whose citizens are excluded from the G8's deliberations.

The economic power of the G8 countries is formidable. They "account for 48 per cent of the global economy and 49 per cent of global trade, hold four of the United Nations' five permanent Security Council seats, and boast majority shareholder control over

[30] The G8 grew from an original Group of 6 that was formed in 1975 following the 'oil crisis' which demonstrated the risks arising from growing economic interconnectedness and the usefulness of political management of increased interdependence. The six founding countries (France, the US, UK, Germany, Italy and Japan) were joined in 1976 by Canada. In 1977 the European Community (now the European Union or EU) became a member but does not have the same status as national governments. Russia achieved partial membership in 1998 and full membership from 2003, completing today's G8.

[31] The G8 and Global Governance (http://www.g7.utoronto.ca/about/g8rg_g8gg.htm). (accessed August 23, 2006).

the IMF and the World Bank" (Corlazzoli and Smith 2005). They also account for roughly 75 per cent of the annual value of development assistance expenditure, and their deep pockets are among the resources that provide them with formidable advantages in trade negotiations and dispute resolution proceedings, both within and outside the WTO (Jawara and Kwa 2003).

The G8 have stated positions on health and globalization, although rarely making an explicit link between the two (Labonté et al. 2004). Commitments related to malnutrition, hunger and famine recurred from 1980 to 1987. HIV/AIDS was first referenced in 1987. The early 1990s were dominated by commentaries on, or commitments to address, illegal drugs and biological weapons. There was passing reference to the need to curb health care costs arising, in part, to an aging population, framed as a net drain on economic growth. The first major statement on health by the G8 did not occur until 1996, from which point both HIV/AIDS and other acute and epidemic infections began to appear regularly in communiqués. With the exception of the 2004 Summit, health issues have become increasingly prominent in G8 agendas (Kirton and Sunderland 2005).

The G8 stance on globalization is exemplified by its statement that "(d)rawing the poorest countries into the global economy is the surest way to address their fundamental aspirations" (Genoa Communiqué 2001, p. 3). This formulation, critics argue, sidesteps the crucial issue of how and on whose terms such countries are to be integrated. The operative model for this integration has been variously described as the Washington Consensus and alternatively as neo-liberal economic globalization.[32] More recently the G8 has been held up as a nimble grouping capable of exercising global governance for health (Kirton and Mannell 2006).

In terms of accountability and transparency, the G8 is an exclusive club of the world's richest and most powerful countries. Can such a club play a representative lead role in global governance for the SDH? Sympathetic observers note that G8 Summits can be assessed more positively on this question when the host country, or other prominent member, is preparing a legacy with less deference to domestic concerns. The role of US President Bill Clinton, in pushing forward the health agenda in Okinawa in 2000, Canadian Prime Minister Jean Chrétien's role in giving Africa prominence at Kananaskis in 2002, and UK Prime Minister Tony Blair's (and would-be Prime Minister Brown's) support for aid, trade and debt relief at Gleneagles in 2005 are prime examples (Kirton and Mannell 2006). Schrecker et al. (in press), however, comment that "the fact that summit agendas are determined by the host country is not necessarily conducive to building momentum around complex issues that inherently require high levels of policy coordination, except in the case where a high degree of agreement already exists among G8 governments". Early reports on the agenda for the Heiligendamm Summit of 2007 indicate that poverty and Africa will figure prominently. Whether this suggests that the SDH may become entrenched, at least indirectly, as ongoing points of G8 policy deliberation remains to be seen. Although national self-interests are undoubtedly a key factor (bio-terrorism, infectious disease, pandemic influenza and other cross-border health risks that figure prominently as health agenda items), the possibility of the G8 forming a nucleus from which the SDH could be effectively tackled must be looked at with some scepticism.

Indeed any G8 claim to be a legitimate and effective force of global governance for health must be rejected until it addresses the question of accountability. Should it involve a larger global constituency of countries beyond the G8, where the impacts of many G8 policies are felt most directly? And should this larger constituency formally include civil society organizations? According to Hajnal (2005), the Birmingham Summit (1998) "was a milestone in G8 interaction with civil society" resulting from the active lobbying for debt cancellation by the Jubilee 2000 coalition and formal acknowledgment of the movement by Prime Minister Blair. The Genoa Summit of 2001 saw broadened consultation with civil society, with on-line discussions, and iterative summary and background documents managed by a university institute. While the violence that took place at the

[32] See Schrecker T, Poon D. (2007), "Globalization, Labour Markets and the Social Determinants of Health," Discussion Paper, Globalization Knowledge Network, WHO Commission on the Social Determinants of Health.

summit reportedly dampened G8 leaders' enthusiasm for such engagement (Kirton and Mannell 2006), the Montreal International Forum, an international NGO established in 1998 to increase civil society participation in global policy forums, convened small 'high-level' invitational meetings between international NGOs and G8 representatives prior to the 2002 and 2003 Summits.[33] The Canadian (2002) and French (2003) governments also provided opportunities for consultation with their nationally based CSOs prior to their summits (Hajnal 2005). The 2004 summit hosted by the US gave no attention to civil society in consultations, briefings or reference in its deliberations. In contract, the 2005 Summit was preceded by a solicitation of CSO inputs that was broader, deeper and more transparent than even many critics of G8 summitry had anticipated. The Live 8 and Make Poverty History campaigns (part of the larger Global Campaign Against Poverty) also played a role in supporting and sustaining Tony Blair's agenda ambitions for the Gleneagles Summit. In 2006, although CSO engagement in St. Petersburg was less visible to the western media, the summit saw the creation of a new organization (Civil G8) which hosted a website,[34] convened two international NGO forums in the run-up to the summit, and provided an invitational private meeting between President Vladimir Putin and 12 international NGOs (Naidoo 2006).

There has been no formal study so far of the extent to which civil society participation affects G8 agendas and outcomes. Smaller NGOs view the more formal participation of "top" NGOs in high-level meetings as a form of cooptation that lends legitimacy to the G8's claim to global governance which, in their view, should remain with the UN (Hajnal 2005). These smaller NGOs have also complained that "coziness" with G8 leaders led to a dilution of criticism and demands made by several NGOs in the run-up to the Gleneagles Summit (Baruchel and Dasilva 2005). These reflect long-standing issues of accountability within, and differences in political strategies among, CSOs themselves. At least in a formal sense, the G8 (with the exception of the 2004 Summit) has increased its engagement with civil society which, in turn, has increased its role *around* G8 events, even if civil society influence on the final Summit outcomes remains somewhat dubious. The crucial normative issue remains whether the G8 *should* view themselves as accountable to civil society constituencies. Nonetheless, momentum for greater civil society engagement is building, reflecting recognition "by everyone, including governments of G8 countries, that civil society is an increasingly important and powerful actor… [that] gives voice to those who have been marginalized or left behind by globalization, as it fights for the universal extension of the benefits of globalization" (Hajnal 2005). Designing mechanisms for civil society engagement is therefore a particularly important task, keeping in mind the many ways in which access to key social determinants of health is affected by the processes of globalization.

Similar conclusions can be drawn regarding G8 efforts to include a broader range of global institutions and world leaders. Heads of the UN, World Bank and IMF are frequently invited to summits – although their roles and who they represent is not clear – with the latter two usually attending G7 Finance Ministers' meetings. However, this openness is only selectively extended to other UN organizations, such as UNDP or WHO. For example, the heads of the International Energy Agency (IEA) and WTO participated in 2005 Summit discussions of climate change and the global economy, and the head of the African Union Commission joined the 2005 discussions of African development. Four African leaders (from South Africa, Nigeria, Senegal and Algeria) participated in the 2002 Summit, where their New Partnership for Africa's Development (NEPAD) was discussed and responded to by the G8 in the form of the latter's Africa Plan of Action. The same four leaders also briefly joined the 2004 Summit and attended the 2005 Summit where their issues figured even more prominently than in 2002. Africa disappeared from the 2006 Summit agenda, although the attendance of Ghanaian President John Agyekum Kufuor at the 2007 suggests renewed attention to the continent. Other country leaders have also been invited to G8 Summits, varying by summit agendas. The unusual inclusion of several Middle East leaders at the 2004 Summit, for example, was in deference to that region being one of that summit's major focuses.

[33] See http://www.fimcivilsociety.org/english/CivilSocietyG8.html (accessed August 28, 2006).
[34] See http://en.civilg8.ru/index.php.

Interestingly a new G8+5 group is emerging that includes leaders from China, India, Brazil, Mexico and South Africa. These five countries were invited to the 2006 Summit, and were among the 15 invited to the 2003 Summit. Reasons offered for their increased participation include their growing economic clout, and their importance with respect to global energy governance and infectious disease control (Kirton and Sunderland 2006). On the one hand, institutionalizing a larger "club" membership might detract from the putative effectiveness and efficiency of the informal G8. On the other, it may be the seed of a more globally inclusive G20, in terms of population, economy and health needs, or a new Group of 20 Leaders (L20), parallel to the G8. A prototype of sorts is provided by the Group of 20 (G20) Finance Ministers, which began meeting in 1999. The G20 consists of the G8 plus Argentina, Australia, Brazil, China, India, Indonesia, Korea, Mexico, Saudi Arabia, South Africa and Turkey. Canada convened and chaired the first two forums and former Canadian prime minister Paul Martin was a strong supporter of this proposal. Some see this as a desirable improvement to present G8 claims to global governance (Kirton 2004; Bradford 2005). But an expanded club also poses substantially greater governance risks to the numerous smaller, economically weaker countries that remain excluded and the dominant role the US would continue to exert in a G/L20 grouping (Carin and Smith 2005; Higgott 2005). There is also concern that such a grouping would further erode the ability of UN agencies with fewer vested interests to act with authority in health and the SDH.

The lesson learned from this case study is that the highly exclusive membership of the G8 is a product of the lack of accountability characterizing global governance in the early 21st century. Its members exert disproportionate power and influence over the world economy including policies impacting on people in low and middle-income countries. Leaders of the developing world are invited as occasional participants, rather than fully fledged members, and remain limited in their capacity to influence key decision-making affecting the SDH. Like the World Bank and IMF, WHO could play a more active role in drawing attention to the governance shortcomings of the G8, even while seeking to participate in G8 deliberations and decisions related to the SDH.

3.3.3 Case study: World Trade Organization

The work of the WTO is defined primarily by the multilateral trade agreements (MTAs) under its auspices. Trade agreements are important to governance because they set the legal framework for member states to participate in the world trading system. The WTO also offers a binding dispute settlement mechanism that interprets and upholds the provisions provided under MTAs. The implications of MTAs for the SDH are addressed by a separate paper of the Globalization Knowledge Network.[35] Capacities to maintain national policy space for development and regulatory action are also dealt with in a separate paper.[36] Here we specifically focus on the impact of trade agreements on health governance at the national and global levels in relation to accountability and transparency of policies set.

In terms of the formal structure, the WTO is relatively democratic compared to other organizations such as the World Bank or IMF (Kovach et al. 2003). In principle the WTO is based on the one-state, one-vote decision making system. In practice, however, most substantive discussion takes place outside formal structures, through a complex series of meetings, such as "mini-ministerials", "green room" meetings and "confessionals". With the complexity of negotiations across multiple areas and wide disparities in the financial and human resources available to developed and developing countries, this results in inequities in bargaining power. Thus, outcomes conform closely to the interests of developed countries or in stalemate. This is even more apparent in bilateral trade negotiations, outside the WTO, which can involve negotiations between even more unequal parties. This is reflected in growing concerns over so-called "WTO plus" commitments.

In terms of transparency and accountability, Blagescu and Lloyd (2006) find that relative to other intergovernmental organizations surveyed, both the WTO and WHO score low against its Global Accountability Index. However, it is important to note that this index

35 See Blouin C. et al., op.cit. for arguments and supporting evidence for/against the relationship between trade liberalization, growth, poverty reduction and health improvement. See also Cornia A. et al. (2007) "Globalisation and health: impact pathways and recent evidence," Discussion Paper, Globalization Knowledge Network, WHO Commission on the Social Determinants of Health.

36 See Koivusalo and Schrecker, op.cit.

is based on particular views of good governance. For instance, it does not address to whom and how accountabilities are realized, an issue when TNCs and NGOs are dealt with. There also remain substantial concerns about accountability in the context of intergovernmental negotiations. Woods and Narlikar (2001) write that decisions made on the basis of consensus may compromise the more representative structure of the WHO (based on one country, one vote). In practice, however, power is asymmetrical among member states and thus not shared equally. This imbalance is even more striking within global economic institutions which do not even boast representative or accountable decision making mechanisms. Jawara and Kwa (2003) raise concerns about the process of negotiation based on interviews with WTO negotiators. They observe that closed negotiations, such as those in WTO ministerials, rather than open access, are the preferred mode, with decisions often made without full approval by low- and middle-income countries. They also document instances of questionable pressures exerted, and inducements offered, by the US and EU delegations, including the use of aid as a bargaining chip. The highly technical nature of many discussions further contributes to the lack of transparency of procedures (Narlikar 2001; South Centre 2003).

The WTO and national policy space

WTO agreements explicitly recognize the right of governments to regulate at the national level. However, as member states, this right must be exercised within the framework of WTO commitments. In the context of agreements, such as the GATT and TRIPS, national policy making must comply with all measures. For other agreements, such as the General Agreement on Trade in Services (GATS), governments retain substantial choice over what sector or mode of services to subject to its provisions. Broadly speaking, trade negotiations and mechanisms can limit or influence the choices available to national policy makers. Governments may be obliged to follow agreed trade rules related to goods, services and intellectual property rights, thus influencing the extent to which a government can regulate them. The protection of intellectual property rights under TRIPS, for example, can restrict the capacity of governments to regulate the price of pharmaceuticals.[37]

The scope available for governments to regulate is especially important in relation to the services sector given that WTO negotiations extend further into the realm of national policy making than the GATT (Fidler 2005b). This applies, not only to the health sector, but also to other health-related services of which governments may seek to restrict free movement, such as alcohol distribution or advertising services (Grieshaber-Otto and Schacter 2001). It is also likely that trade-related regulatory frameworks on goods and services will be extended to state subsidies and government procurement, already part of a plurilateral[38] agreement. The start of negotiations on government procurement of services has been written into the original GATS agreement. The extension of MTAs to these areas may restrict the capacity of governments to adopt national policies that seek to reduce, for example, geographical inequalities or address local production and employment problems.

Trade agreements do not only liberalize the trade of goods and services, but also strengthen intellectual property rights. Particular attention needs to be drawn to the financial implications of protecting IPRs in terms of higher costs of new pharmaceuticals. This issue continues to be widely debated in relation to HIV/AIDS and access to affordable antiretrovirals, but it is a broader problem in the context of access to health care and technologies. Bilateral trade agreements have also become the subject of intense debate due to some requiring stronger IPR protection than TRIPS. For example, in the case of the US-Korea Free Trade Agreement negotiations, pharmaceutical policies and pricing have been a key area of negotiation (Cutler 2006; Nam 2006; Vershbow 2006). Industrial and trade policy prioritizes the protection of IPRs, thus restricting the scope by which national governments can regulate the cost of patented pharmaceuticals and technologies, or gain access to or share knowledge related to health and health-related products.

37 See Correa C (2007) "Intellectual Property Rights and Inequalities in Health Outcomes," Discussion Paper, Globalization Knowledge Network, WHO Commission on the Social Determinants of Health.

38 A plurilateral agreement of the WTO is one signed only by those member states that wish to do so, in contrast with multilateral agreements to which all member states are party.

Global governance of health and trade

The relative roles of the UN and its specialized agencies on the one hand, and the WTO on the other, are complicated by the fact that the WTO is empowered with a binding process of dispute settlement that strengthens implementation of its measures. While inequitable, in terms of the potential impact of trade sanctions on bigger versus smaller economies, this process has been considered by some to be a potential governance vehicle for promoting the SDH. Specifically, some NGOs have campaigned for the incorporation of substantive health, labour and environmental issues (so-called social clauses) into WTO agreements. Although perhaps intuitively appealing, others argue that this is problematic for several reasons. Many developing countries see such clauses as primarily another means of protectionism by high-income countries through the "back door". Labour issues have received particular attention, eliciting contrasting views from NGOs and trade unions in low-income countries (O'Brien 2000). With respect to such clauses, there is concern over the lack of social policy expertise within the WTO. This may enhance trade-related perspectives of such issues, at the expense of measures taken by social policy institutions that can deal with regulatory issues more comprehensively and not merely with respect to trade policy. A stronger social policy role for the WTO could also hamper effective dealing of trade issues with questions that trade officials are neither appropriate nor equipped to answer. At the same time, they could undermine the roles of existing institutions, such as the ILO, WHO, UNESCO and FAO.

WHO and FAO have engaged with the WTO since its inception in 1995, largely through the Codex Alimentarius and SPS Agreement. In relation to labour standards, the ILO remains more distant. While the WTO might formally recognize existing international norms and agreements, it does not necessarily recognize UN agencies for global standard setting. Indeed, the WTO has delegated standard setting to such organizations as the International Organization for Standardization (ISO) which describes itself as occupying "a special position between the public and private sectors" (ISO 2006).[39] An issue of concern is the extent to which the ISO — as a network of national standards institutes in 157 countries — might expand its role in terms of technical standards for health and health-related services. To what extent should health or public interest-related tasks be given to an organization where private sector interests are strongly represented? Particular attention has been drawn to problems arising from ISO standard setting for tobacco products (Yach and Aguinaga Bialous 2001; Han 2001).

The setting of norms and standards by different global institutions is not a problem when their decisions do not conflict. Moreover, Lamy (2006a) notes that the jurisdiction of the WTO does not supersede that of other international law:

> The WTO, its treaty provisions and their interpretation, confirms the absence of any hierarchy between the WTO norms and those norms developed in other fora: WTO norms do not supersede or trump other international norms.

However, when priorities and aims differ, efforts to achieve greater coherence can lead to the framing of health-related issues within trade and other economic priorities. Thus, ministries of health may be required to coordinate with more politically powerful ministries of trade and industry on IPRs and export promotion to improve coherence. Although this may lead to greater accommodation of health or development concerns in economic policies, it is more likely that health policies are adjusted to be complementary to, or supportive of, economic objectives. For example, at the national level this could mean that, while poverty reduction measures could deal with the SDH outside the macroeconomic framework, such measures would need to be coherent with that framework. At the global level, WHO may be invited to address access to medicines and other trade-related matters, but only as long as actions are coherent with the aims and policies of the WIPO and WTO.

These concerns are evident in the WHA resolution on trade and health which emphasizes coherence between

[39] Member institutions of the ISO vary in their affiliation. As stated on the ISO website, "many of its member institutes are part of the governmental structure of their countries, or are mandated by their government. On the other hand, other members have their roots uniquely in the private sector, having been set up by national partnerships of industry associations."

health and trade policies (WHO 2006). On what basis and under which framework is coherence sought? This is reflected in the dilution of the resolution to emphasize the need to assess the benefits and challenges (but not risks) of trade agreements to health. One issue for global governance, therefore, is how to assess the implications of trade agreements without being undermined by adverse impacts on vested trade interests. It is important that WHO not be reduced to a secondary helper of global trade policies, but that it has the resources, knowledge and independence to help governments promote and protect health from potentially adverse trade measures.

In trade policy essential decisions are made by senior trade officials as part of the dispute settlement process. WHO has observer status on the Committee on Sanitary and Phytosanitary (SPS) Measures and the Committee on Technical Barriers to Trade (TBT), but only ad hoc observer role in the committees dealing with IPRs and services. It has no status on the General Council, Committee on Government Procurement, or working parties on GATS rules, domestic regulation, and transparency in government procurement, in spite of the potential importance of negotiations in these areas to national health systems. The problems of presence and substantive expertise were highlighted by the post-Doha and TRIPS Council negotiations. According to Raghavan (2000b), while economic diplomats discussed which diseases in which developed countries constituted a public health problem, the representative of WHO was not permitted to offer advice or even to attend the meetings.

Particular attention has been drawn to NGO criticism of the WTO. However, business-oriented NGOs have long been more closely engaged with WTO negotiations and trade treaty drafting than public interest NGOs. At the Singapore Ministerial (1996), for example, 65 per cent of official NGOs present were business organizations (Scholte et al. 1998). This influence extends to the dispute settlement processes. While governments nominally control access to these legal processes, in practice large corporate interests are often closely involved in the initiation and conduct of litigation by their governments (Keohane 2001). The active involvement of international NGOs and corporate lobbying was especially important in the development of international legal frameworks and actions on IPRs and the TRIPS agreement (Braithwaithe and Drahos 2005; Drahos 1995). However, simply increasing broader and more representative CSO participation in or around the WTO may not resolve this imbalance. This is because such groups are likely to seek limits on commercial interests in ways that run counter to the WTO's very raison d'être to increase the flow of goods and services across borders.

Rather, global and national level decisions on necessary public health measures or standards setting should be made on the basis of health concerns and health policy priorities separate from trade considerations. Decisions on health policies in the context of trade disputes should be made on the basis of knowledge about health policies (including their impacts on the SDH), and not by senior trade policy officials whose terms of reference remains one of enhancing global trade. One of the ideas vetted by the World Commission on the Social Dimensions of Globalization, for example, was to refer disputes based on developing countries' development goals to a panel of development/health/human rights experts to determine if the abrogation of trade treaty rules was necessary to achieve the stated purpose. These could be extended to incorporate their actions to reach the MDGs or to fulfil their obligations under the right to health.

There are four lessons learned from this case study. First, if governance at the WTO is to take greater account of health (and notably the SDH), it is essential that the goals and norms existing UN agreements, human rights treaty commitments and the work of specialized agencies, notably WHO, are recognised in trade policies. The impacts of trade policies extend to all sectors, and these sectors need to be given due consideration. In terms of global governance, this might mean cross-referencing of WTO agreements with those agreed in other spheres; formal participation of other UN bodies in relevant WTO committees; and a role by non-trade organizations in the dispute settlement process on issues relevant to their areas of expertise. For WHO, this would mean a requirement by the WTO to call on its expertise when assessing a health-related issue or resolving a dispute. This means a much stronger role for WHO in trade issues, boosting its capacity to offer health-oriented advice to governments, and strengthening its ability to inform all SDH-related discussions at the WTO.

Second, there is a need for substantive debate about the transparency and accountability of trade negotiations and policy making within the WTO. This requires strengthening accountability, from the national to global levels, of trade policies for their social and environmental impacts. In relation to the SDH, the relevance and influence of specific trade policies are unclear when negotiations take place.

Third, the current standard-setting mechanisms for trade policies need to ensure that regulatory needs to protect and promote health (including the SDH) are not undermined or misused by powerful corporate actors. The governance of the ISO needs to be critically assessed to ensure that its role does not extend inappropriately, interfering for example with WHO's mandate or into areas with significant health relevance such as biologicals. Similar attention should be given to WHO's work with the Codex Alimentarius.

Fourth, it should be recognised that economic globalization will benefit in the longer term from policy decisions giving due attention to health considerations. Taking account of the SDH does not compromise trade interests, but rather improves the sustainability of trade policies.

3.4 Participation and representation

In broad terms there has been an increased number of institutional actors in global health since the 1990s, spanning state, market and civil society. It is often assumed that this more crowded institutional environment reflects greater pluralism. With the increase in the number of institutional actors and the greater prominence of non-state actors and hybrid arrangements, the nature of the new political pluralism in global health must be critically assessed. What is the quality of representation within global institutions that influence the SDH? Who are the different stakeholders involved in specific issues? How are they represented within the relevant institutions? To what extent can we link a focus on the SDH with quality of representation in institutions of global governance? Is there a new global health elite emerging that enhances, rather than reduces, health inequalities? Our review suggests that considerable progress remains to be made in achieving democratic representation in global governance institutions concerned with the SDH.

The greater participation of non-state actors in global governance is largely seen as positive for representation. However, non-state actors often comprise commercial entities seeking to further their economic interests. For example, industry participation in the Codex Alimentarius Commission (CAC) has raised concerns about the protection of consumer interests (see 3.4.3). So-called "astro-turf" (false grassroots) organizations have increased to lobby for certain interest groups and are even sponsored by other organizations (e.g. patient groups funded by industry). Financial ties and affiliations may not be declared, raising concerns regarding conflicts of interest and even covert intent. The funding of front groups by the tobacco industry, with the intent of undermining tobacco control efforts, is well documented. The International Tobacco Growers' Association (ITGA), for example, describes itself as "a non-profit organisation founded in 1984 with the objective of presenting the cause of millions of tobacco farmers to the world."[40] Analysis of internal industry documents shows, however, that the ITGA in reality is "a public relations vehicle created in the 1980s by the tobacco industry to front its lobbying against international tobacco control initiatives by giving the industry a human face and a Third World grassroots voice" (Must 2001, p. 2).

3.4.1 Case study: Global Fund to Fight HIV AIDS, Tuberculosis and Malaria

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is a non-profit foundation established in 2001 to support global efforts to fight HIV/AIDS, tuberculosis and malaria. The Fund was created in response to consensus among high-income countries, notably at the G8 Summit of 2000, and to campaigning by NGOs for increased access to anti-retroviral treatments. The purpose of the Fund is to attract, manage and disburse additional resources that will make a sustainable and significant contribution to the reduction of infections, illness and death (Global Fund 2006). To achieve this, it was recognised that innovative forms of global governance were needed that would bring together diverse stakeholders across the public and private sectors (Ollila 2003).

[40] International Tobacco Growers Association. Who we are and what we do. http://www.tobaccoleaf.org/ (accessed October 17, 2006).

The Fund is comprised of four governing, administrative and advisory bodies. The *Foundation Board* is the supreme governing body with responsibility for setting policies and strategies, making funding decisions, and "all other powers to carry out the purposes of the Fund." The Board consists of twenty voting members as follows: seven developing countries; eight donor countries; and five representatives from civil society and the private sector consisting of an NGO from a high-income country, one NGO from a developing country, one private foundation, one representative from the corporate sector, and one representative of an NGO who is a person living with HIV/AIDS or from a community living with TB or malaria. The four ex-officio non-voting members are one representative each from WHO, UNAIDS, the trustee (the World Bank manages the fund as a trustee), and one Swiss citizen. The process of selecting each Board member is left to each group represented, and the Board Member must serve as representatives of their constituencies for a two-year period.

The *Technical Review Panel* is described as "an independent, impartial team of experts appointed by the Foundation Board to guarantee the integrity and consistency of an open and transparent proposal review process" (Global Fund 2006, p. 8). The 17-member panel reviews applications and makes recommendations to the Board. The Partnership Forum is convened at least once every two years to provide persons and entities concerned with the three diseases "a forum to express their views on the Foundation's policies and strategies" (Global Fund 2006, p. 3). Participation is ostensibly open to a wide range of stakeholders including donors, multilateral development cooperation agencies, civil society, technical and research institutions and the private sector. The Forum reviews progress based on reports from the Foundation Board, provides a platform for debate, advocacy and fundraising, mobilizes political support, and provides a communication channel. The Fund's day-to-day work is carried out by a Secretariat housed by WHO in Geneva. The Secretariat is headed by an Executive Director, shortlisted by a Nomination Committee and selected by the Board "based on merit, in a non-political, open and competitive manner" (Global Fund 2006). The Executive Director serves as the chief executive officer for a term of four years, renewable for not more than one additional term of three years.

In many ways, the governance of the Fund has been innovative in its efforts to broaden and achieve an appropriate balance of representation. The provision of voting rights to non-state actors (i.e. NGOs and private companies) on the Board is unprecedented in such initiatives. Decisions made in Board meetings, agendas and attendees lists are made publicly available through the Fund's website. The creation of the Partnership Forum as a platform for an even broader range of stakeholders seeking to influence the activities of the Fund is also unusual. Overall, the Fund emphasises support for programmes that reflect national ownership and correspondence with country-led policy formulation and implementation, rather than a prescribed strategy intended for all recipient countries.

Nonetheless, these innovations must be appraised in terms of their success at achieving meaningful and appropriate representation. First, there are ongoing debates concerning the appropriate balance in number of representatives for each constituency. Should NGOs, for example, be provided with more than two seats on the Board? Second, to what extent are the decision-making processes used by various constituencies, in selecting their representatives, democratic? How does the NGO community, for instance, select its two representatives given thousands of diverse organisations? How representative can selected members be of their constituencies? Third, the relegation of WHO, UNAIDS and other UN bodies to non-voting members of the Foundation Board, while representatives of NGOs, private companies and foundations are given voting rights, has been called into question. The former are accountable to member states of the UN system while it is unclear to whom the latter are accountable. Finally, there remains debate about whether certain issues should receive greater attention. In relation to the SDH, the Fund's relatively narrow and vertical focus on three diseases raises questions about its impact on health systems strengthening. Indeed, while the Fund's terms of reference are seen to provide focus and help in mobilizing funds, this is recognised as potentially creating difficulties of integration with existing national health systems, as well as detracting from non-focal diseases and health programmes. In addition, Hanefield et al.[41] have found that there are few programs that address the underlying factors contributing to women's vulnerability to HIV

41 See Hanefield et al. (2007), op.cit.

infection, such as a lack of programs tackling gender relations and gender violence, although the Fund has created some environments that appear relatively inclusive, namely the country coordinating mechanisms. From the fifth round of requests for proposals from countries, health systems strengthening are included as an explicit category of activity.

The lesson learned from this case study is that, while tackling the SDH requires the meaningful involvement of a broad range of stakeholders in relevant decision-making bodies, clear criteria should exist on how different interests will be represented, the accountability of stakeholder organizations to their own constituencies, and selection processes for stakeholder groups. Global institutions must democratize their formal decision making to accommodate broader participation. Current forms of informal and ad hoc participation are largely insufficient, and there is a need to create new political spaces where global constituencies, which include state, market and civil society actors, can contribute. At the same time, the involvement of broader constituencies must go hand in hand with an appropriate mandate to tackle the SDH.

3.4.2 Case study: Codex Alimentarius Commission

The Codex Alimentarius was created in 1963 by the FAO and WHO to be "the single most important international reference point for developments associated with food standards" (FAO/WHO 2005, p. 1-2). Commission has 172 member states, and the WTO uses it as an international reference point for the resolution of disputes concerning food safety and consumer protection. During its existence, it has adopted around 250 standards which together comprise the Codex Alimentarius (Food Code).

Codex meets annually (alternately in Rome and Geneva) with plenary sessions attended by up to 500 country representatives. National delegations are led by senior officials appointed by member states. Delegations may, and often do, include representatives of industry, consumer organizations and academic institutes. Countries that are not yet members of the Commission sometimes attend in an observer capacity. A number of international governmental organizations and international NGOs also attend in an observer capacity. Although they are "observers", the tradition of the Codex Alimentarius Commission allows such organizations to put forward their points of view at every stage except in the final decision, which is the exclusive prerogative of member states. To facilitate continuous contact with member countries, the Commission, in collaboration with national governments, has established country *Codex Contact Points* and many member countries have *National Codex Committees* to coordinate activities nationally.

Criticism has been raised about the extent to which the food industry is represented within the Commission, and thus the balance achieved between the goals of trade and consumer protection. According to the report Cracking the Codex (Avery et al. 1993), 81 per cent of non-governmental participants on national delegations came from industry between 1989 and 1991, while only 1 per cent represented public interest groups. The study examined participation on all Codex committees that met between 1989 and 1991, finding that industry representatives accounted for 26 per cent of all participants. Industry participation increased on committees dealing with particularly controversial issues. For example, one-third of the 387 participants in the two meetings of the Committee on Pesticide Residues were industry representatives, and 86 of these participants represented specific agrochemical and food companies; only three participants at these meetings represented public interest groups. Forty-one per cent of the participants in the two meetings of the Codex Committee on Food Additives and Contaminants were food industry representatives. On the Codex Committee for Nutrition and Special Dietary Uses, 47 per cent of participants represented industry.

This imbalance in the representation has led to lower food standards which favour trade over consumer protection. Many Codex standards are lower than national ones, allowing, for example, residues of some of the most hazardous pesticides in the world. Residues of these pesticides are banned or strictly limited in many countries of the world. Lang writes, "With an increased role for Codex, nations will effectively hand a great deal of control over the regulation of food safety and quality to global trade and corporate interests" (as quoted in Avery et al.1995).

For the Codex Alimentarius Commission to be a global governance mechanism that more effectively protects and promotes the SDH, an improved system

of representation and participation by a broader range of stakeholders, notably groups representing consumer interests, is needed. This is especially relevant given the enhanced role of Codex in trade liberalization, and growing evidence of the links between weak global food regulation and nutrition-related health problems.[42]

The lesson learned from this case study is that there is need for closer scrutiny of representation in key standards setting bodies affecting the SDH. What specific standards are set can affect vested interests positively or negatively. Efforts to address the SDH can be hindered by standards which unnecessarily restrict the capacity of the poor to participate in the world trading system, or by standards that insufficiently protect consumers. The political nature of decision making by standards setting bodies, like the CAC, should be acknowledged; even with a more equitable balance of representation by the diverse interests concerned, standards set by such bodies, and the science upon which they rest, should be critically reviewed by independent external panels annually.

Box 2.

SPS and the EU ban on hormone-treated beef

The best known SPS case was an EU ban on foreign beef that contains artificial growth hormones banned in Europe because they may be carcinogenic. The dispute panel ruled against the EC ban partly because international standards had been set for five of the six hormones in question. The SPS (III.1) prefers government regulations to be based on international standards, specifically those of the Codex Alimentarius Commission. What the dispute panel ignored is that the Codex adopted a "safe" level of hormone use by a very narrow vote of 33 to 29, with seven abstentions (only country representatives are able to vote); and that Codex itself has been criticized for having an overwhelming majority of corporate scientists with very limited participation by civil society organizations. Standards-setting and risk assessments are not simply "scientific", they are also political and contested, particularly in the case of uncertainty. In adhering narrowly to the requirement for a risk assessment, this decision placed the burden of proof on the EU to show that beef imports were unsafe, rather than on the USA and Canada, who brought the dispute forward, to show that they were safe.

Source: Labonté R, Sanger M. (2006) Glossary of the World Trade Organisation and Health: Part 1. Journal of Epidemiology and Community Health, 60: 655-61.

3.4.3 Case study: The People's Health Movement and its bottom-up approach

The People's Health Movement (PHM) is a global network of health activists and campaigners established in 2000 seeking to revitalize the principles of the Alma-Ata Declaration on Health for All and primary health care, and to revise international and domestic policies that negatively impact on health status and systems. In doing so, it has become an active supporter and critic of WHO. Built on grassroots participation and representation, PHM now has a presence in some 80 countries. The PHM manifesto is the People's Charter for Health (2000), now available in over 40 languages. The Charter embodies:

- an expression of PHM common concerns
- a vision for a better and healthier world
- a call for more radical action
- a tool for advocacy for people's health
- a worldwide rallying manifesto for global health movements, as well as for networking and coalition building.

The objectives of the PHM are:

- To promote Primary Health Care (Health for All) as a key equity, participation and inter-sectoral goal, as well as a human rights issue
- To encourage governments and their health agencies to ensure universal access to quality health care, as well as to education and social services according to people's needs and not people's ability to pay
- To promote the participation of people and people's organizations in the formulation, implementation and monitoring of all health and social policies and program

42 Hawkes C., Chopra M., Friel S., Thow A.M. (2007), "Globalization, food and nutrition transitions," Discussion Paper, Globalization Knowledge Network, WHO Commission on the Social Determinants of Health.

- To promote health, equity and sustainable development as top priorities in local, national and international policymaking
- To encourage people to develop their own solutions to local health problems
- To hold local authorities, national governments, international organizations and corporations accountable for their actions, especially those related to the SDH.

The PHM is coordinated by a global secretariat (previously in Bangalore, India and now in Cairo, Egypt), and supported by a steering group consisting of regional focal points, a smaller coordination committee and representatives of a number of specific "thematic circles". The PHM is organized around geographic circles at country and regional levels, as well as issue-based thematic circles that are linked though local, national and international level campaigns. India has the most organized "circle" and is present in many Indian states. PHM also maintains an active website (www.phmovement.org) and an active list server forum (pha-exchange@kabissa.org) which serve as lifelines for the organization. Finally, two world assemblies have been held to bring together activists from the world over (Savar, Bangladesh 2000; Cuenca, Ecuador 2005).

As a growing actor in global health governance, the significance of the PHM is:

- Its stance derives from perspectives gathered from a bottom-up decision-making process explicitly seeking to achieve participatory and democratic representation.
- Its membership is broadly based and focused at the grassroots level.
- It seeks to express the interests and perspectives of the poor and marginalized from across the world (those who currently do not have sufficient voice and influence).
- It encourages people to develop their own local solutions.
- It recognizes diversity of interests and perspectives in its activities.
- It encourages people to hold to account local authorities, national governments, international organizations and national and transnational corporations.

The lesson learned from this case study is there is a significant and broadly based global constituency sufficiently dissatisfied with existing global governance institutions to organize an alternative forum. This coalition explicitly challenges the lack of democratic governance characterizing major global institutions, in favour of governance defined by participatory principles. One of the key purposes of the PHM has been to give a voice to those currently excluded from global forums, and to diversify the views represented within them as a means of improving the governance of global health.

3.5 Resource mobilization and allocation

A separate paper on international finance[43] discusses financing mechanisms for allocating resources to the social sector including health, and how changes in global financing have an impact both on health status and the health sector.[44] This section focuses on how the governance of financing of, and by, global institutions support or undermine the SDH. How can we assess the quality of governance concerning the mobilization and allocation of global resources in terms of their impact on the SDH? How can the global governance of financing be improved?

The foremost issue concerning the global governance of financing is how decisions are taken regarding the use of funds. This is directly related to the source of funding and how they are managed. Among health-related organizations, WHO's regular budget funds (RBFs), over which the organization has discretionary control, has remained largely static in real terms, totalling US$915 million in 2006, as a result of the non-payment of arrears or freezing of contributions by some major donors. In contrast, extra-budgetary funds (EBFs), over which donors choose to exert varying degrees of control, have grown in relative terms since the early 1990s, reaching US$2,398 million in 2006 (Lee and Buse 2006). Along with concerns about the sustainability of EBFs, there are questions about WHO's capacity to establish a coherent work program given this funding structure. For donors seeking to demonstrate accountability to domestic constituencies

43 See Taylor, op.cit.
44 See Rowson, op.cit.

in the relatively short term (i.e. political cycle), funds tend to be earmarked for vertical disease-focused activities. As a result, longer term and large scale funding to tackle structural factors that contribute to ill health, receive limited support (Shiffman 2006). For example, substantial EBFs have been given to the Expanded Program on Immunization (EPI) and GAVI to immunize against major childhood diseases. However, limited efforts are made to address the social conditions in which children become more prone to such diseases, such as poverty, poor housing and sanitation.[45]

Funding of the UN system as a whole faces long-standing problems concerning the capacity of major financial contributors to use funding as a tool for furthering their political agendas. There are three main categories of UN expenditure: regular budget which is financed by a mandatory assessment from the member states; peacekeeping budget which is also financed by assessment but is separate from the regular budget; and voluntary contributions which finance most of the humanitarian relief and development agencies. Under this system, member states share in the financial support of core activities, but each country pursues its own priorities in the other budgets. On grounds of dissatisfaction with the UN, some member states have refused to pay their assessed contributions in full or on time, leaving the UN system financially vulnerable. This is illustrated by the terms of the Helms-Biden Act whereby the US government has offered to pay a proportion of its UN arrears (US$1.3 billion) in return inter alia for reducing US assessed (from 25 per cent to 22 per cent) and peacekeeping contributions, and no growth of the UN budget in real terms. Substantial arrears of US$244 million, not covered by the Helms-Biden Act, remain outstanding, including US$214 million to various UN organizations (Biden 2001). Moreover, under the existing system, humanitarian relief and economic development are not considered core UN activities. For example, UNDP, UNICEF and UNFPA are all dependent on voluntary contributions. Correspondingly UN funding to address the SDH fall largely under voluntary contributions, leaving initiatives subject to the decisions of donors, rather than embedded as a core budget line.

Given financial uncertainty and chronic underfunding, there have been increased efforts to secure alternative sources of funding for development purposes. One source has been the initiation of innovative funding mechanisms, such as the International Finance Facility (see 3.5.2) and UNITAID (see 3.5.3), to generate additional resources, support acquisition of vital supplies, or provide increased bargaining power for countries in need. The PAHO Revolving Fund for Vaccine Procurement, for example, was created in 1979 to 1) provide countries with a continuous supply of vaccines that meet PAHO/WHO standards at affordable prices; 2) enable countries to procure the required supplies of vaccines and syringes for immunization activities, thereby preventing interruptions due to lack of vaccines or immediate funds; 3) facilitate the use of local currency for the reimbursement of invoices; 4) consolidate vaccine and syringe contracts for bulk purchasing, which results in more advantageous prices and improved delivery; 5) assure quality of vaccines being used in national immunization programs; and 6) establish procedures with suppliers to permit urgent orders to be placed and delivered on short notice (PAHO n.d.).

Another important funding source has been the private sector and civil society (Piore 2002; Richter 2004). Philanthropic organizations, which straddle the two spheres, have become especially prominent in global health since the 1990s (Cohen 1999) with the scale of their resources raising familiar questions about the governance of such funds. As well as concerns about donor driven decision-making, existing problems of coordination, short-term emphasis on disease-focused interventions, and the creation of undue burdens on recipient countries may be worsened (Barder and Birdsall 2006).

Finally, there has been substantial funding of global public-private partnerships since the mid 1990s, largely targeted at specific diseases or health issues (Buse and Walt 2000). There has been limited critical analysis of GPPPs, including how they are funded and for what purposes. In relation to the SDH, given their disease-focused nature, existing GPPPs are unlikely to be appropriate mechanisms. There are also concerns about

[45] For a fuller discussion of WHO finances, see Vaughan J.P., Mogedal S., Kruse S., Lee K., Walt G., de Wilde K. (1995), Cooperation for Health Development: Extrabudgetary funding in the World Health Organization (Oslo: Governments of Australia, Norway and UK), ISBN 82-71-77 3941; and Lucas A., Mogedal S., Walt G., Hodne Steen S., Kruse S.E., Lee K., and Hawken L. (1997), Cooperation for Health Development, The World Health Organisation's support to programmes at country level (London: Governments of Australia, Canada, Italy, Norway, Sweden and UK).

potential conflicts of interest between the need to tackle issues such as poverty and inequality through fundamental structural change, and the vested interests of private sector "partners" in the existing economic order.

Overall there remain stark irrationalities in funding, apparent both within and across health-related institutions. As long as funding for development purposes remains voluntary, and major donor countries earmark such funds to satisfy domestic constituencies, limited global resources will be available to address the SDH. Moreover, it may be argued that the funding decisions of health-related institutions can only have marginal effect unless core institutions in global governance, notably the IFIs, act to change underlying global economic and political structures that impact on the SDH. To address these problems, a range of ideas have been put forth to make better use of existing resources, and to mobilize new sources of financing (Kaul and Conceição 2006).

3.5.1 Case study: The finances of the Global Fund to Fight AIDS, Tuberculosis and Malaria

The aim of the Global Fund is to raise US$7-10 billion annually to fight three major diseases. While falling far short of this sum thus far, pledges have increased to reach US$2 billion in 2006 (see Pledges and Contributions, www.theglobalfund.org). The Global Fund's structure as a public-private partnership was expected to result in substantial funding from non-traditional sources, notably the private sector. To date the Global Fund has relied almost exclusively on traditional development aid, as private sector contributions have been negligible.

On the allocation of resources, the Fund is a financing mechanism, not an implementing agency. Thus, it does not have a country presence but focuses on providing support to projects proposed by governments (Principal Recipients). For the first five funding rounds, 57 per cent of the funds have gone to HIV/AIDS related projects, 27 per cent to malaria and 15 per cent to tuberculosis. In terms of geographic distribution, 55 per cent has been given to countries in sub Saharan Africa, 14 per cent to East Asia and the Pacific Region, and 9 per cent to South Asia, the Middle East and North Africa. Both Latin America and the Caribbean, and Eastern Europe and Central Asia, have each received 11 per cent of funds. Much of the Fund's support has gone to financing drugs to prevent and treat the three diseases, with 48 per cent of the funds used to procure drugs and commodities. Another 22 per cent has been used to support human resources and training, and 11 per cent on infrastructure and equipment. Most funds have gone to government (64 per cent), with NGOs (12 per cent), multilateral agencies (18 per cent) and the private sector (4 per cent) receiving the remainder.

A more detailed analysis of the Fund's governance is provided above (Section 3.4.1) and in a separate Commission paper.[46] Criticisms of its role as a financing mechanism have included the following:

- The Fund has not attracted the anticipated amounts of funds, and concerns of sustainability are raised in terms of programs initiated, and the possibility of starting new programs.
- There are concerns that resources for the Fund are from existing development aid resources. This may impact on the sustainability of other development efforts. Overall total volume of ODA decreased substantially during the early 1990s (an era of "trade not aid"), a trend that only recently began to reverse.[47] Proportionate and absolute funding levels for health, however, have steadily increased.[48,49]
- The Fund channels resources for three diseases and there are concerns this biomedical focus compromises the development of more comprehensive health systems. Round Five of funding has invited specific proposals for strengthening health systems and human resources to promote greater access to the products and services previously funded.

46 See Hanefield et al., op.cit.

47 Debt cancellation continues to be counted as ODA contributions and has meant that little new net funding in the past two years has been contributed, although foregone debt repayment does increase revenues in eligible debt-relief countries for public spending on health and other SDH. Once debt cancellation to just two countries (Iraq and Nigeria) is removed, however, total ODA and debt cancellation in 2006 was actually below levels in 2005.

48 OECD (2000) Recent trends in official development assistance to health. (Paris: Organisation for Economic Co-operation and Development, September). http://www.oecd.org/dataoecd/12/0/6877046.pdf (accessed September 20, 2006)

49 See Taylor S., op.cit.

- The Fund is strongly focused on health technologies and gives limited attention to structural factors impacting on the diseases, such as poverty, gender or multi-sectoral approaches. This appears to reflect the process by which proposals are put forth by Principle Recipients, reviewed by the Technical Review Panels, and funded in terms of performance.

The lesson learned from this case study is that the Global Fund has not attracted the amount of new funding hoped for by the global health community to tackle three major diseases, and practically no funds have come from new sources. Efforts have been made to disburse funds to recipient countries in ways that support national governments and health systems. However, efforts to strengthen health systems development have thus far been remained modest. The creation of the Global Fund to vertically focus on three diseases, and the ways in which decisions are taken to allocate funding, means that limited attention so far is being given to addressing the SDH.

3.5.2 Case study: The International Finance Facility

The UK government launched a proposal in January 2003 for an International Finance Facility (IFF) designed to aid achievement of the MDGs. It is estimated that development assistance must double (an increase of at least US$50 billion per year), and be focused on the poorest countries, if the MDGs are to be met. By comparison, donor governments at the UN International Conference on Financing in Monterrey in 2002 pledged an additional US$16 billion a year from 2006.

To bridge this resource gap, the IFF is a financing mechanism which would provide up to US$50 billion per year in development assistance between now and 2015. It would leverage this additional money from the international capital markets by issuing bonds, based on legally binding long-term donor commitments. The IFF would be responsible for repaying bondholders using future donor payment streams, and would disburse resources through existing multilateral and bilateral mechanisms. Since its launch, the proposed IFF is described as receiving "broad interest and support from the emerging markets, developing countries, "international institutions, faith communities, NGOs and business" (UK HM Treasury 2006).

In 2005 the International Finance Facility for Immunization (IFFIm) was formed for "frontloading" (up front investment) aid for immunization programs and health systems development to 2015. An anticipated IFFIm investment of US$4 billion is expected to prevent 5 million child deaths between 2005 and 2015, and more than 5 million future adult deaths. Supported by Brazil, France, Italy, Norway, Spain, Sweden and the UK, the scheme funds the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization). The IFFIm will have a financial base comprised of legally binding payment obligations from sovereign donors. It will borrow operating funds in the international capital markets over the next 10 years, up to a prudently limited proportion of the sovereign obligations making up its financial base (gearing ratio). Given the strength of its backing from largely triple-A-rated sponsors, and its conservative financial policies, IFFIm is expected to be rated triple-A by credit rating agencies.

In terms of governance the IFF is potentially innovative. As a funding mechanism, it offers more reliable and predictable funding than traditional development aid. This is because it is not reliant on annual decisions regarding public expenditure on aid budgets and thus the changeable political climate of individual countries. This means that potentially it would be more responsive to funding needs over a longer timeframe. However, there remain concerns about the funding mechanism itself, and whether it addresses underlying weaknesses in the governance of development finance. Issues regarding the scheme itself include the following:

- Some analysts have questioned the capacity of the poorest countries to spend such large amounts of aid (US$50 billion annually), and of their economies to cope with such rapid change (Mavrotas 2003), suggesting a need to consider means of increasing such capacity ahead of major increases in disbursements.[50]

[50] There are concerns that scaling up aid disbursements to developing countries lead to so-called "Dutch disease" (DD) which effects growth and human development, notably as a result of inflation and exchange rate appreciation. The UN Millennium Project argues strongly against this problem. See Chapter 17 at http://www.unmillenniumproject.org/reports/fullreport.htm. The IMF (2005) finds no DD effect in sample countries and concludes that the empirical evidence is "mixed". Research for the IMF by Rajan and Subramanian (2005a; 2005b) also suggests that the overall effect is not statistically significant.

- The need for bonds to be serviced and repaid from future aid budgets suggests that future (post-2015) aid disbursements will be reduced unless such payments are explicitly excluded from donor countries' commitments to provide 0.7 per cent of their gross national income in aid.
- How can the rich countries justify paying US$220-US$244 billion in interest charges to (presumably) wealthy bondholders over the life of the Facility (Moss 2005), rather than devoting these resources directly to meeting basic needs in developing countries?
- In that regard, would the IFF actually contribute to increased global income inequalities, as compared with the counterfactual of a system of tied international taxes using a broad and generally progressive international tax base (Jubilee Research 2003)?

Many concerns about the governance of the IFF focus on who will decide how the funding mechanism will work, and how funds will be spent. A report by the World Development Movement (2005) acknowledges the treasury's plan to provide funds as grants, debt relief and highly concessional loans and use existing institutional structures. However, it raises questions about what proportion of funds will be disbursed through multilateral versus bilateral channels, given the commitment to take donor preferences into account when deciding which countries will receive funds and how. Moss (2005) challenges the capacity of the IFF to raise additional resources for development, and argues that the benefits will be outweighed by its additional financing costs. Finally, what "high level principles" will specifically apply to how donors disburse IFF funds, and its actual governance structure remains subject to negotiation. This includes how recipient countries will "have a significant role within the facility". In short, while the potential for the IFF to mobilize substantial funds for the MDGs have been welcome in many quarters, governance issues concerning how the funds will be managed and disbursed require careful consideration.

The lesson learned from this case study is that there is a need for innovative ways of raising additional resources for development purposes. How effectively and equitably such funds will be raised and used, to tackle the underlying structural causes of poverty and ill-health will depend also on innovative governance of such funds. Additional funds without addressing the dominance of donors in how funds are used may simply add to the shortfalls of existing funding mechanisms. Funding models that essentially borrow from the future through the sale of bonds must further ensure that the public costs of that borrowing do not increase income inequalities by dent of who is most able or likely to purchase such bonds.

3.5.3 Case study: UNITAID

Also known as the International Drug Purchasing Facility, UNITAID was launched in 2006 by Brazil, Chile, Norway and France, with support from about 40 other countries, international organizations, NGOs, and private foundations. The idea is to levy a surcharge on airplane tickets, which will vary according to destination and travel class, in implementing countries (to date Brazil, Chile, Congo, Cyprus, Gabon, Côte d'Ivoire, France, Jordan, Luxembourg, Madagascar, Mauritius, Nicaragua, Norway and the United Kingdom) to raise funds for purchasing drugs for HIV/AIDS, tuberculosis and malaria and support public health systems in poor countries. As described by UNITAID, "Air transport is one of the industries that benefits most from globalization with an average annual growth of 5 per cent. It is therefore appropriate for this industry to help redistribute the benefits of globalization. Using differentiated rates according to the travel classes ensures that efforts are distributed fairly among passengers" (UNITAID n.d.). Additional multi-year budgetary assistance will also be provided from other countries.

It is believed that this scheme will better respond to the needs of poor countries in terms of production volume, price level and drug suitability. It also provides a more sustainable, and a growing source of, funding in the longer term. Moreover, UNITAID can use its purchasing power to leverage price reductions for quality drugs and diagnostics, and accelerate the pace at which they are made available.

UNITAID is described as complementary to existing organizations, such as WHO, UNAIDS, UNICEF and the Global Fund to Fight Aids, Malaria and Tuberculosis. It does not seek to replace existing organizations

that help facilitate access to drugs by poor countries. Instead, it plans not to setting up a new bureaucracy, forging partnerships with existing bodies and initiatives, and thus reducing the risk of duplication. Specific details on the governance and operation of UNITAID have yet to be defined. According to its website, this will result from "broad consultations with the players concerned as well as NGOs and civil society."

The lesson learned from this case study is that there are opportunities to raise tax revenues from activities arising from increased globalization. Like the IFF, however, raising additional funding must be accompanied by appropriate governance mechanisms that ensure that funds are used to address the SDH.

3.6 Leadership in global governance and the SDH

Leadership can be defined as "the ability of an individual to influence, motivate, and enable others to contribute toward the effectiveness and success of the organizations of which they are members" (House 2004, p. 15). Bull (1977) argues that the contemporary state system is anarchical in that there is no higher level of authority over states, with each state exercising sovereignty over its territory and citizens. In international relations order is provided through common rules and institutions through which an international society is formed.

It is useful to reflect on the nature of leadership in global governance, how it is distributed among key institutions, and how such leadership (or lack of it) impacts on the SDH. As the recognized exercise of authority, leadership is clearly lacking in health- and non health-focused institutions relevant to the SDH. With formal authority residing with sovereign states, intergovernmental organizations remain subject to the will of member states. State compliance with international treaties, such as the FCTC, depends on acquiescence by states, with sanctions for non-compliance often remaining non-enforceable. There are few examples of states conceding their sovereignty, to "supranational" organizations with higher powers. Certain functions of the European Union are perhaps the best example, although trade treaties – because of enforceable sanctions – also represent degrees of erosion of national sovereignty.

Amid the absence of overarching legal or political authority at the global level, other forms of leadership become important. Technical leadership in health can be identified as broadly residing in WHO. As a UN specialized agency, WHO is widely recognized as having access to unrivalled technical knowledge and expertise in health. Member states, notably low- and middle-income countries, look to it to undertake a wide range of activities, such as assigning nomenclature, issuing guidelines and standards, and reviewing and coordinating research. While other institutions hold specialist expertise on selected areas, WHO and its extensive global networks can provide such broadly based health expertise. The key question, however, is whether technical leadership alone is sufficient to achieve real progress on the SDH?

Moral or ethical leadership can also be considered an important factor in global governance. This is the power to influence public opinion and behaviour with or without recourse to political or legal authority. Such power arises from shared support of certain values and principles seen as underlying decision-making and action. It is clear that fundamental decisions that affect the SDH all have nominative dimensions. These include the allocation of scarce resources, access to health care, and priority setting across populations and their needs. During its first two decades, WHO's strong biomedical focus brought limited engagement with such value-laden choices. However, by the 1970s its attempt to address broader determinants of health was driven by principles of social justice, fairness and equity. These include such groundbreaking initiatives as primary health care (PHC), the essential medicines list and the International Code on the Marketing of Breastmilk Substitutes. Some high-income countries argued that WHO was engaging inappropriately in "political" issues. Others applauded it for demonstrating moral (and political) courage and leadership, and encouraged its role in acting as "the world's health conscience" (Kickbusch 1997) by challenging powerful vested interests. CSOs representing vulnerable and marginalized populations are seen as playing a similar role. The moral and ethical perspectives of different global institutions compete today for leadership amid a more crowded policy space in global health (Lee and Buse 2006; Horton 2006). The ascendance of the World Bank and the creation of global public-private partnerships (Buse and Walt 2000) not only

reflect the political and economic balance of power, but also the power to lead through ideas, values and ethics. Advocates of the human rights-based approach (HRBA) see this framework as a much needed return to an ethical and political focus indispensable for revitalizing leadership in global health.

Finally, leadership unequivocally arises from control of financial and other resources. While WHO may exert technical and moral leadership, its relatively limited resources and human rights orientation prevent it from exercising this leadership effectively. Moreover, the growth of health sector lending by the World Bank, together with the creation and funding of GPPPs, has undermined WHO's capacity to carry out its mandate with commensurate policy decisions and actions.

Overall no single institution is recognized as providing decisive leadership in global governance related to the SDH. Instead, there are different forms of leadership that reside in different institutions. While this may be seen positively as a rational division of labour based on comparative advantage, in reality it is more a misalignment of different types of authority. The World Bank has relatively substantial resources to address the SDH, but it is mistrusted in many countries and large portions of the NGO community, not least because of the shortcomings in its governance structure. WHO has recognized technical expertise, but limited financial means and has to rely on other institutions to apply this expertise. The PHM is vying for a more prominent position in this misalignment.

Most problematic is the perceived erosion of the ethical authority of WHO. While Bale (2003) calls for WHO to "build partnerships with the pharmaceutical industry", Hardon (2003) argues that WHO has come under undue commercial influence at the expense of equity-focused policies. Horton (2003) warns of "a damaging reinterpretation" of WHO's mandate. The diversity of institutional actors concerned with global governance is accompanied by a split of ideologies and value systems underlying their actions. Consensus around certain normative principles — such as social justice and equity — has strengthened in many institutions, though actions have not necessarily always followed. At the same time, other value systems — such as economic and managerial efficiency — remain dominant. This has resulted in an increased emphasis on short-term results being monitored and evaluated, as well as in an increased use of new health technologies, (i.e. emphasis has been on technology-centred vertical approaches that fit with these premises).

3.6.1 Case study: The global public goods approach

The concept of global public goods is based on the premise that "[i]n today's world, globalization has brought about interdependencies that blur the distinction between domestic and external affairs. The best way to ensure one's own well-being is to be concerned about that of others" (Kaul and Faust 2001, p. 869). The concept of global public goods (GPGs) is intended to help determine when governments should work collectively to address an issue of shared interest based on the distinction between "private" and "public" goods. A pure "private good" (e.g. a cake) is one whereby consumption can be withheld until payment is made and, once consumed, cannot be consumed again. A pure public good (e.g. a lighthouse) has two important characteristics: (a) use by one individual does not limit its use by others of the same good; and (b) once provided it is available to all others (Woodward and Smith 2003). Traditionally governments are expected to play an active role in providing public goods as, left solely to the market, such goods would be undersupplied.

In recent years, the concept of public goods has been applied to the health field in an effort to distinguish what functions can best be fulfilled by the state or by the market. The prevention, control and treatment of communicable diseases can be usefully understood in this way. All individuals within a society benefit from minimizing the spread of communicable diseases. Furthermore, there are certain market failures that would lead to the undersupply of many goods:

- There is little incentive for individuals to privately invest in such goods. Benefits from the creation of a disease surveillance system are shared by all within a society and cannot be withheld until payment is received. Individuals benefit from disease surveillance whether or not they have paid.

- The problem of "free riders" will arise if certain functions, such as immunization programs, are left to the market. While a population's collective risk from measles, for example, declines at a given rate of vaccination, there may be an individual incentive to "free ride" on the compliance of others. If sufficient numbers acted in this way, and immunization coverage declined sufficiently, this could lead to a disease outbreak that would pose a risk to all non-immunized individuals.
- Because they affect limited numbers or marginal populations, there are certain health needs that do not offer a sufficient economic return to entice the market into action. So-called neglected diseases attract inadequate attention by pharmaceutical companies, for example, because of the small numbers affected or the inability of sufferers to pay for treatment. In such cases, governments are required to mobilize alternative resources or create additional incentives to address such diseases.
- Increased health risks can arise from individual or collective behaviours which represent a negative externality (public bad) for society. Regulatory measures are needed to ensure that such behaviours (e.g. smoking) are minimized.
- Situations where action leads to collective benefits rather than individual gain require governments to pool costs among all individuals. The overall benefit to society of, for example, a disease surveillance system far exceeds its cost, but only if this cost is collectively shared. Similarly, the cost-effectiveness of disease eradication (e.g. polio) cannot be realized unless governments invest in such campaigns.
- If left to the market alone, public goods are not produced in sufficient quantity and it becomes necessary for governments to act.

The concept of GPGs is increasingly prominent in high-level policy discussions of financing for global health and the MDGs. In relation to the SDH, however, how useful is it? Deneulin and Townsend (2006) argue that the concept may not be an appropriate paradigm for the development of global strategies to improve well-being. Mooney and Dzator (2003) similarly argue that GPGs do not sufficiently address issues of equity in health outcomes. Smith et al. (2003) propose collective action in collective interest as an alternative and broader organizing principle for similar reasons. In short, GPGs' underlying premise is that shared interests are the key rationale for collective action. As UN agencies, and particularly the UNDP and WHO, continue to advance work on the GPGs concept, it is important that ongoing research on the equity implications of the concept be strongly supported.

The lesson learned from this case study is that approaches that appeal to utilitarian principles can encourage powerful interests to contribute to global initiatives if self-interest is recognised. However, the concept of global public goods has limited applicability to many of the SDH, and is therefore unlikely to provide a sufficient rationale for generating global leadership.

3.6.2 Case study: The Right to Health

The Office of the United Nations' High Commissioner for Human Rights (2006) defines the human-rights based approach (HRBA) as "a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. It seeks to analyse inequalities which lie at the heart of development problems and redress discriminatory practices and unjust distributions of power that impede development progress." Key legal texts include:

- The 1948 Universal Declaration of Human Rights (UDHR) which states that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his [sic] family" (Article 25)
- The 1966 International Covenant on Economic, Social and Cultural Rights which specifies the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12)
- General Comment 14 by the UN Committee on Economic, Social and Cultural Rights (2000) which sets out states' specific legal obligations "to respect, protect and fulfil" the rights cited under Article 12.

These obligations are explicated by Chapman (2002) and Nygren-Krug (2002). Conventional wisdom is that they apply only to the actions of national governments with respect to people living within their borders. But, even apart from the 1966 Covenant, philosopher Thomas Pogge argues that cross-border obligations follow from Article 28 of the UDHR, which specifies that, "Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized." In the context of globalization, the human rights rubric is especially valuable since, if human rights are to be meaningful at all, they cannot be contingent on validation with reference to some external criterion such as one's wealth or economic productivity. It thus provides a basis with a foundation in international law for challenging erosions of health equity associated with the emergence of a global marketplace.

No effective supranational mechanisms analogous to the institutions of trade policy and law exist to ensure respect for these requirements, which represents a glaring deficiency in the institutions of global governance. In 1997, UN Secretary-General Kofi Annan stated

Box 3.

The People's Health Movement and the Human Rights Based Approach

The HRBA is about the more equitable distribution of resources in society according to need, and health is identified as one of the key entry points to achieving this goal. There is a broad range of human rights embodied in international agreements. Those most relevant to the SDH are:

- The right to life, liberty and security of a person
- The right to the highest attainable standard of health
- The right to fair and favourable working conditions
- The right to adequate food, housing and social security
- The right to education.

Led by the People's Health Movement, advocates of the HRBA believe that, to tackle the SDH, the approach can be incorporated as a positive force in global governance institutions, notably WHO, UNICEF, the World Bank, GFATM, UNFPA and UNAIDS, as well as be applied at the country level (People's Health Movement, 2006). Doing so, however, will require changes to the mandates of these organizations and a fundamental shift in paradigm. More detailed independent evaluation is needed of the extent to which the relevant institutions presently incorporate a HRBA in their work, and how different institutions can incorporate the HRBA in their policies as soon as possible.

The PHM launched a global campaign in 2006 to strengthen the "right to health" (RTH), with a focus on defending and operationalizing the "right to health care" by mobilizing action from below. The campaign looks at what measures are needed to tackle human rights violations in the context of a broader analysis of power and social inequalities. It seeks social transformations indispensable to resolving such inequalities as they affect health. As such, the campaign focuses on changing national and global health sector reform policies that affect access to health care by the poor, the disadvantaged and the marginalized. It also seeks to put in place mechanisms to effectively redistribute resources.

The role played by PHM activists is to document violations of the Right to Health and its underlying determinants, and to plan joint action with claim holders and duty bearers to stop these violations. Capacity building of PHM cadres and partners in civil society, responsible for calling duty bearers to account, is seen as indispensable in this process of social mobilization. During the campaign, the documenting of violations will not be restricted to those in the sphere of health care, but will encompass denouncing violations of health rights related to the various SDH. The country circles will continue to expand their involvement in local initiatives that tackle the most important SDH concerning the violation of health rights.

PHM is counting on the potential of major social mobilization to achieve change as much as the RTH care campaign demands for decision-makers to take responsibility. The campaign also focuses on processes that lead to potentially concrete outcomes for which beneficiaries have genuine claims. In phase I of the campaign, PHM will carry out about 30 country assessments of the status of the RTH case.

that all UN bodies were to apply the HRBA. However, how this should be done and what this meant for each UN agency remained unclear. This suggests that more detailed independent evaluation is needed of the extent to which relevant institutions presently incorporate a HRBA in their work, and how different institutions can incorporate the HRBA in their policies as soon as possible. In 2002 the United Nations Commission on Human Rights appointed a Special Rapporteur on the right to health for a three-year period (an appointment renewed in 2005) with the following tasks:

(a) gather, request, receive and exchange right to health information from all relevant sources;
(b) dialogue and discuss possible areas of cooperation with all relevant actors, including Governments, relevant United Nations bodies, specialized agencies and programmes, in particular WHO and the Joint United Nations Programme on HIV/AIDS, as well as NGOs and international financial institutions;
(c) report on the status, throughout the world, of the right to health, including laws, policies, good practices and obstacles; and
(d) make recommendations on appropriate measures that promote and protect the right to health.[51]

Since his appointment to the post, the Special Rapporteur (Paul Hunt; http//www.ohchr.org/english/issues/health/right/index.htm) has addressed issues that affect the right to health. They include health worker migration, poverty reduction strategies, trade agreements, health systems, mental health care, neglected diseases, access to medicines, maternal mortality and indigenous populations (Hunt 2003a, 2003b, 2004a, 2004b, 2004c, 2005a, 2005b, 2005c, 2005d, 2006a, 2006b). Most recently (Hunt 2007), he has provided examples of the operationalization of the Article 12 obligations within individual national jurisdictions. The role of the Special Rapporteur is arguably valuable in continuing to bring national and international attention to potential abrogation of this right through other multilateral or global policies. It is recommended here that an independent evaluation of the policy impact of the Special Rapporteur be undertaken, along with consideration of establishing the post permanently and of alternative ways of establishing the HRBA as a cornerstone of multilateral institutions' approach to global health governance.

The lesson learned from this case study is that the human rights-based approach offers a framework for tackling the SDH directly. It represents a fundamental shift in the current development paradigm, towards massive capacity building, concerted efforts to document violations of the right to health care, and a revising of the mandate of WHO and organizations working with it. The approach has received growing attention and support from UN organizations and a growing number of NGOs. The role of the UN Special Rapporteur has been critically important and should continue as a permanent post.

[51] Personal communication, Jude de Bueno Mesquita, Office of the UN Commissioner on Human Rights, 2006.

4.0 Conclusions and recommendations

This wide-ranging review can only provide a partial view of the diverse and complex governance challenges faced in efforts to address the SDH. Nonetheless, a number of conclusions can be drawn from the analysis:

1. The past two to three decades have brought a period of transition from international to global governance including health governance. Societies around the world are faced with the challenge of finding more effective means of collectively addressing issues of global relevance.

2. Global governance should not be assumed to apply to all spheres or levels of social cooperation. *Global governance* may be needed when interests, rights and obligations are shared across constituencies, but are not being furthered by individual governments acting alone. Global governance may be appropriate where the articulation of shared interests, the establishment of rights and obligations and the mediation of differences require collective action by more than one state (e.g. air traffic control, migration). Where such interests, rights, obligations and differences can be addressed within a lower level of the jurisdiction, other levels of governance may apply.

3. The SDH address how societal conditions affect health status, abilities to remain healthy or cope with illness and preventable ill health. How globalization impacts on the SDH is the subject of other GKN discussion papers. However, an understanding of those linkages requires assessment of the governance of the institutional actors involved. This concerns the nature of governance of individual global institutions, as well as the global governance architecture as a whole, as they pertain to the SDH.

4. The emergent global governance architecture relevant to the SDH is characterized by the following features:

- There is "thick" governance[52] in certain issue areas, notably economic relations such as trade, investment and finance, but "thinner" governance in other issue areas notably the social sectors. This uneven level of global governance reflects the extreme inequality of *de facto* and *de jure* power, with the result that the world economy is managed in ways that systematically enhance the interests and magnify the power of the already wealthy and powerful, while reinforcing existing dynamics of marginalization and disempowerment and creating new dynamics with the same effect. Despite increased recent attention to selected global health issues, resulting in the creation of various individual initiatives, addressing the SDH has not yet been given sufficient priority in the building and running of effective global governance institutions.
- The relative balance of power among state, market and civil society institutions has shifted radically in recent decades. The private sector (market) and civil society have gained more prominent roles at the global level, including institutions concerned with global health, while state institutions have seen a relative decline. There has also been a shift in power, from social and political institutions (e.g. WHO, ECOSOC), to those concerned with management of the world economy (e.g. IMF, World Bank, WTO).
- Within each type of institution, there is a greater concentration of power into fewer hands at the global level. Large transnational corporations, major industrialized countries and mostly Northern-based "international" non-government organizations have come to dominate global governance, while many remain marginalized by the current architecture. Economic globalization defined by economic growth has been prioritized over social and environmental protection.
- A certain degree of innovation has characterized some mechanisms within global institutions concerned with the SDH. Of particular note are institutions, such as the GFATM, which bring together state and non-state actors for the purpose of addressing issue areas that cross or circumvent national borders. However, these innovations to broaden representation within global governance with non-state actors, most notably the corporate sector, has been accompanied with the simultaneous reduction of the power of the competent UN bodies, and have in that way been conducive to further fragmentation and confusion of the global governance on these essential health issues.

5. There has been increased attention to the SDH through poverty reduction strategies and the MDGs in a number of global institutions. However, there remain concerns that these initiatives have lacked genuine commitment and been narrowly interpreted in their implementation, focusing on technical interventions and measurable outcomes rather than on underlying structural factors. The MDG to reduce poverty is a notable exception, although both its ambition (reduce by half) and its metric (poverty at US$1-a-day level) have been criticized as inadequate in the context of the growth in global wealth (Pogge 2004; Reddy and Pogge 2005). For example, Edward (2006) proposes an ethical poverty line based on life expectancy to replace the US$1-a-day metric.

6. In addition, the focus of many GPPPs is on disease-oriented activities and biomedical interventions, as opposed to changing the broader structural conditions which affect the SDH. Similarly, the SDH are not easily translated into results-based approaches as those adopted by the private sector, such as pilot funding and rapid measurable results, which have gained widespread popularity among donors. In addition, there is a tendency for health-based institutions to propose solutions and actions that primarily fall within their own somewhat narrow or biomedically inscribed mandates, rather than recommendations that are more dependent on activities of

[52] The concept of "thick" and "thin" governance is defined by Held et al. (1999) in reference to the degree to which governance institutions have formed around a given issue-area.

other organizations. This leads to compartmentalization, lack of effective overall coordination mechanisms, and insufficient attention being paid to the SDH by the former institutions. The need to reorient medical research, to take greater account of neglected diseases and their underlying and structural causes, has repeatedly been stressed by the global health and development policy communities, but to date to limited effect.

7. Any efforts to address the links between global governance and the SDH require engagement with both health and non health-focused institutions. However, this is not easy due the range of institutions involved. Where powerful non-health interests prevail, there are profound difficulties in gaining sufficient attention and political priority for health issues in general and for the SDH in particular.

8. There is strong evidence at the national level that good governance is an important factor in addressing the SDH (Sen 1981; Lake 2001; Franco et al. 2004; Ruger 2005). Strengths and weaknesses in national governance might be applied to the global level where there is a need for fuller assessment of how good governance contributes to tackling the SDH. For example, lessons from the national level suggest that health-based administration is essential for intersectoral policy making. If transferred to the global level, WHO should play an equivalent role in supporting global policy making on the SDH.

9. A broad concept of good governance, including issues of power, offers a more appropriate framework for assessing the quality of emerging forms of global governance than one focused for example on public sector management. Such a framework (a) assesses the governance of state and non-state institutions; (b) uses criteria which go beyond measures of technocratic or administrative effectiveness; and (c) includes critical assessment of the quality and functioning of political processes and systems within and across relevant institutions.

10. This paper's review of selected global institutions, against key criteria of good governance, points to a number of weaknesses that are detrimental to tackling the SDH:

- The long-standing *problems of coordination and coherence*, characterizing global institutions in general, extend to institutions concerned with the SDH. These problems remain despite efforts to encourage greater cohesion among: (a) organizations operating within a single country or region (e.g. donor consortium); (b) organizations working across sectors (SWAp); and (c) organizations working on the same thematic area (e.g. PRSP) or health-related issue (e.g. UN Ad Hoc Inter-agency Task Force on Tobacco, IMCI). There remains a clear hierarchy among global institutions, a persistent lack of effective coordination mechanisms, or sanctions for non-compliance with those that exist. In large part this reflects differences in underlying values and perspectives. Powerful interests remain unwilling to submit to coordination mechanisms, where they exist, that reduce their capacity to act if they do not agree with the fundamental purposes of these mechanisms. For the SDH, the existing configuration of institutions has evolved in an *ad hoc* manner, with the issues of poverty and inequality being added to existing mandates, rather than fundamentally changing them. At the same time, institutions with closely overlapping mandates have proliferated. The resulting patchwork of institutional mandates, activities, authority and resources reflects the absence of an agreed plan or agreed strategic vision to tackle the SDH.

- The key global institutions affecting the SDH *have inadequate systems of transparency and accountability*. This is especially true of the G8, WTO, World Bank and IMF, but also of the large charitable foundations which could play an important role influencing the SDH. Despite efforts to engage with a broader range of stakeholders, improve public information systems, and provide fuller reporting of activities, the transparency of key decision-making processes remains inadequate. There

is also considerable variation in the degree to which global institutions are accountable and to whom. In principle some institutions are formally accountability to all member states. In practice they are accountable to donor governments, internal stakeholders such as boards of directors, or a combination of these. Too few institutions have formal lines of accountability to populations affected by their activities. There are also concerns that funding for global health has shifted from institutions accountable to a relatively broad constituency, such as WHO, to those with limited accountability, such as the GFATM and the Gates Foundation. The result is even greater asymmetries between the capacity to affect the lives of constituencies, and accountability for such actions. A more critical assessment of the quality of transparency and accountability mechanisms remains needed. Foremost, there is need for an overall system of "checks and balances" within and across global institutions to ensure collective transparency and accountability.

- There have been some efforts to *diversify representation* within global institutions concerned with the SDH, but limited efforts to redistribute power within them. Led by WHO, the negotiation of the FCTC allowed a prominent role for CSOs. GPPPs are governed in varied ways combining state, market and civil society institutions. These vary in the degree to which there are opportunities for non-state actors to contribute to formal decision making. There also remains debate as to what the balance of representation among key constituencies should be in emerging forms of global governance, notably the most effective balance to tackle the SDH. There is a clear tension between the need to accommodate diverse perspectives, through a plurality of institutions, and the optimal use of limited resources through coordinated action. How can the SDH be served best?

- Although resources for global health have increased in recent years (e.g. to GPPPs and to initiatives to strengthen cooperation on global health issues such as pandemic influenza) *the governance of resource mobilization and allocation has remained firmly under the control of major donors*. Decisions continue to reflect accountability to foreign and economic policy goals, and to domestic constituents which, given electoral cycles, tend to favour short-term projects and measurable outcomes. Efforts to raise additional funds, such as UNITAID and the IFF, have been praised for raising awareness of the need for increased resources. However, concerns remain about their governance and, in the case of the IFF, its means of resource mobilization. These should be seen as an opportunity to reflect on how governance of resource mobilization and allocation may be strengthened.

- There is a distinct *lack of overall leadership* among global institutions affecting the SDH in terms of formally recognized authority. Biomedical expertise lies firmly within WHO. Other forms of technical expertise are held by the World Bank (e.g. economics) and other institutions, while financial power remains with the IFIs and major donors. CSOs may command moral weight, but lack the financial clout to assert leadership over other institutions. The effectiveness of efforts to build cross-sectoral links and action through theme or issue-based initiatives (e.g. Poverty Reduction Strategies) has been constrained by the failure to redistribute authority and resources for such purposes.

In summary, the SDH are not well served by the current system of global governance, either in the field of health or more generally. This system was broadly established in the 1940s, with the creation of the IMF and World Bank following the 1944 Bretton Woods Conference, and the United Nations following the 1948 Dumbarton Oaks Conference. While many changes have occurred since, these have been piecemeal, generally in response to particular concerns of the time, and driven at least as much by political considerations as by global interests. The result is a system whose effectiveness and efficiency is undermined by a proliferation of institutions, institutional rivalries, sometimes unclear or questionable allocations of

responsibilities, and often inadequate or ineffective coordination mechanisms. At the same time, the legitimacy of organizations, and their effectiveness in achieving their goals, are undermined by governance structures that reflect the values and power dynamics of the colonial era rather than the 21st century, and entrench rather than offset inequalities in political and economic power. This has resulted in a misdirection of resources. It has also skewed priorities away from the social determinants of health towards economic interests and the geopolitical agendas of major powers, with potentially serious adverse consequences for health.

In broad terms, the overall structure of global governance should be fundamentally reviewed, in the context of the needs, priorities and political culture of the early 21st century. While such a process would clearly need to go beyond the SDH, these determinants – with other concerns not recognized as priorities in the 1940s, such as environmental sustainability – must clearly play a central role in this process. Such a fundamental review would necessarily need to take place outside existing structures, in a purpose-specific forum akin to the Bretton Woods and Dumbarton Oaks conferences. It is imperative for the legitimacy and effectiveness of the process that it should be universally inclusive and representative, with democratic representation for all citizens on an equal basis; fully transparent and accountable; and independent of sectional interests. Building global institutional and intergovernmental support for such a large but important governance initiative requires WHO to promote this goal among its member nations, and the global institutions with which it presently actively partners.

While this forms the major recommendation arising from this paper, several more specific ones follow:

1. There needs to be more critical, detailed and systematic assessment of health and non-health focused institutions, individually and collectively, in terms of their *de facto* concern and impact on the various SDH, and the effects of their governance structures in this context. This should inform the process of reform needed to identify appropriate responsibilities among relevant institutions, and to improve their governance structures. WHO should assume institutional leadership in undertaking this assessment, working with an arm's length group of partner institutions, CSOs and independent researchers/scholars (Lee et al. 1996; Kickbusch 2005; Fidler 2005b).

2. The contemporary global governance architecture is dominated by institutional and policy perspectives that currently constrain action to effectively address the SDH. The first step in a reform process to correct this imbalance is development of criteria for good global governance related to the social determinants of health, based on the assessments recommended above. Again, WHO should assume institutional leadership in this regard (UNDP 1997; Lee and Goodman 2001; Labonté et al. 2004).

3. As an initial product of the reform process (as above), WHO member states should be encouraged to give higher priority to addressing the SDH. WHO should reflect that priority by allocating substantial and commensurate core funding, by hiring more social scientists and nurses and by building the corresponding capacity of its staff. This is to be achieved through the agreement of a strategic document describing how WHO will be more influential in addressing the SDH, and through the adoption of an ad hoc resolution in the WHA to this effect. Other relevant stakeholders notably those currently underrepresented within global institutions are to be engaged in this endeavour (Global Health Watch 2005).

4. It is recommended that WHO play a lead role in providing scientific and technical support for action to address the SDH. This review of existing global institutions finds WHO to be the most appropriate focus for this work. However, the organisation must adapt and apply its technical expertise to achieve a focused action agenda which gives much greater emphasis to tackling the SDH. WHO should also monitor trends on key indicators, and serve as the central forum for policy debate on such issues.

5. To effectively play this role, WHO's independence from sectional interests, and the symmetry of its accountability to member states needs to be more effectively ensured. Its conception of health, and institutional structure, should also move decisively beyond a vertical, disease-specific and bio-medically focused model, towards a more holistic and multi-disciplinary model which makes a reality of the maxim that "health is not merely the absence of disease but a complete state of physical, mental and social well-being". WHO staffing should reflect this more multi-disciplinary approach, giving appropriate weight, and equal status, to professionals from other relevant disciplines such as sociology, anthropology, development, international and macroeconomics, political science, agriculture (e.g. in relation to food security, food safety and nutrition) (Peabody 1995).

6. WHO should seek a resolution for formal support of SDH in WHO and to ensure longer time frame for work and activities. An initial list of such work (which requires an accurate assessment of, and funding for, additional human resources) would include:

- using the Commission report towards establishing this role and engaging other like-minded international organizations in this process, including if possible, other relevant specialized agencies and organizations, such as UNRISD, WIDER, UNIFEM and UNEP
- convening a broader conference or sets of meetings on the SDH (and global governance implications) with one or several international organizations, with special reference to the UN/DESA, ILO and UNRISD, which all have shown active interest in the SDH
- broadening and strengthening its presence in international trade committees, trade negotiations and WTO Ministerial Meetings, and making explicit statements and articulation on issues which are of importance to health and the SDH
- engaging more forcefully with the donor-community and other international organisations on the SDH, to ensure that the links between the SDH on the one hand, and global economic issues and poverty reduction on the other are established, and that global vertical campaigns on targeted diseases do not compromise broader needs of health systems and health policy priorities
- linking up SDH indicators with health equity impact assessments and health systems work so as to ensure that national level policy and program action on the SDH does not remain a rhetorical tool
- offering technical assistance and guidance for countries on policies and measures that focus on addressing the SDH
- working actively with staff and governance bodies of the ILO to advance the recommendations arising from the Commission in light of efforts to move forward on recommendations from the World Commission on the Social Dimension of Globalisation
- providing a specific website – as part of www.who.int or elsewhere — with accessible literature and existing information on the SDH.

7. There is a need for stronger consensus and more concerted coordination of relevant global institutions if the SDH are to be tackled effectively. It is recommended that ECOSOC be strengthened and, together with WHO, formally tasked to oversee such work, with relevant UN organizations including WHO reporting to it. Such strengthening should follow the recommendation of WCSDG that ECOSOC upgrade its level of representation, including an executive committee at ministerial level and inter-ministerial interaction on key global policy issues.

8. CSOs can better coordinate their actions aimed at influencing the key global institutions affecting the SDH. This should include the setting up of a "monitoring and watchdog" program around discrete subject, areas such as the actions of the WHO Executive Board, the implementation of relevant WHA resolutions, WHO-corporate partnerships, the strengthening of relevant regional and WHO country level programs, and the appropriate mix of professional backgrounds and skills of

WHO staff. The WHA should grant CSOs increased representation in its proceedings, and the management committees of major WHO programs relevant to the SDH.

9. The human rights-based approach should be used as an analytical and normative framework and advocacy tool in support of the SDH by WHO and other multilateral institutions. The UN Special Rapporteur on the Right to Health should be established as a permanent position within the UN system, and be provided with sufficient resources, to provide a focal point for such action. It should remain independent of WHO, reporting to the UN. Its role should that of a watchdog ensuring in part that WHO fulfils its leadership function effectively. It should also have a mandate and resources to initiate investigations into any allegations of poor governance, inappropriate resource prioritization or resource allocation, and technical incompetence by any global institution in matters related to the SDH.

10. WHO should strengthen its promotion of the use of human rights instruments among its members, including development of a requirement for annual reporting on the progressive realization of the Right to Health, the manner of which would be developed in collaboration with the UN Special Rapporteur.

11. Global institutions whose policies impact significantly on the SDH, notably WHO, the World Bank, IMF and WTO, should be required to include health ministries and relevant CSOs in key decision-making bodies and negotiations on issues substantially affecting the SDH.

12. Alternative financing mechanisms, more independent of political interference by individual donors, should be systematically assessed and adopted. WHO should actively support and advocate for various forms of taxation at the global level (e.g. Tobin Tax, UNITAID) as sources of funding that are potentially substantial, more sustainable, fair and politically independent. Innovative means of allocating resources that address the SDH should also be vigorously pursued.

Finally, it is imperative that all global institutions redistribute power over decision-making to achieve more equitable and meaningful representation of a fuller range of relevant stakeholders. At the same time, evidence shows it is also imperative that public policy making on health, and the organizations concerned, maintain an appropriate distance from industrial policies and interests. This returns to our overarching recommendation that identifies the need for a systematic review of the overall system of global governance. A redistribution of power within and across global institutions inevitably follows whatever normative criteria are promulgated and advocated by champions for such redistribution. Recognizing this, we conclude in Box 4 with a discussion of some of the normative principles that could form the basis for discussion within WHO, and its multilateral partners. It is further recommended that there be an annual reporting requirement of WHO staff to the WHA on efforts towards building a critical mass of global institutions prepared to move toward a redistribution of decision-making power, how WHO has changed its own governance processes in line with the principles below, and ultimately its progress in addressing the SDH.

Box 4.

General normative principles for reforming global governance

A key objective of global governance is to enable the global community to achieve collective action in its collective interests. This requires a democratization of institutions and processes to ensure that influence over decisions appropriately reflects the balance of interests between countries and population groups.

In dealing with these issues, it is essential that long-term needs and objectives be given due weight, despite the short time-horizons which characterize national governments. This suggests a need to consider alternative mechanisms for the selection of representatives by, and their accountability to governments – for example, shifting this role from the executive to the legislative branch.

Given the inter-connectedness of economic, social and environmental issues (not least in relation to health), it is also essential that the basis of the structure be on a holistic rather than a fragmentary approach. This requires an appropriate overall structure and division of labour between agencies, avoiding proliferation of agencies in closely related or overlapping fields. It should also ensure effective mechanisms for collaboration and coordination in areas where different institutions mandates intersect.

In any international institutional framework, decisions affecting the social determinants of health at the global level should observe the right to "participation of the population in all health-related decision-making at the community, national and international levels" (http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument para 11).

Principles of democracy, accountability and transparency

All international institutions should observe democratic standards accepted at the national level in countries generally accepted as democratic. This includes decision-making processes in which:

a) all people and countries are represented
b) votes are based on equal representation of countries or in relation to population, and not weighted by economic variables
c) representatives are directly or indirectly accountable to the populations they represent (this might be better achieved through election by and accountability to legislatures rather than executives)
d) all representatives have resources and opportunities to influence decisions proportional to the effects of such decisions on those they represent
e) representatives are independent of, and not subject to undue influence by, interest groups other than the populations they represent
f) full transparency of all processes is consistently observed
g) those represented are able to express their views to their representatives before decisions are taken, on the basis of full information and documentation
h) all decisions are taken through processes which conform to these standards
i) effective independent mechanisms are in place to ensure conformity with these standards.

Heads of all international organizations should be selected through transparent mechanisms that conform to similar standards, and are based on the merits of candidates rather than political considerations. Consideration should be given to the establishment of a standing body, with members elected by parliamentarians on a regional basis, with responsibility for appointing the heads of all international organisations on the basis of advice from ad hoc committees of specialists it would convene for each appointment.

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Publications of the Globalization Knowledge Network

Towards Health-Equitable Globalisation: Rights, Regulation and Redistribution; Report to the Commission on Social Determinants of Health
Ronald Labonté, Chantal Blouin, Mickey Chopra, Kelley Lee, Corinne Packer, Michael Rowson, Ted Schrecker, David Woodward and other contributors to the Globalization Knowledge Network.

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