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# **The Interfacing of Developing Countries' National Strategies with Global Governance: Conflicts and Co-operation in the Health Sector**

## **A Framework for Research**

### **(1) Globalisation, Health and Global Governance**

Globalisation is a multi-faceted process, encompassing all basic aspects of social change. It is a long-term historical process; but it has greatly accelerated since the 1970s. At least this last phase of globalisation has been driven by economic forces and political decisions towards the creation of global markets (GATT/WTO, structural adjustment) and we witness an evolutionary process of adjustment of the political framework to the economic drive for globalisation. Related to this is an all-encompassing process of "global socialization" which implies challenges to the basics of governance within national societies and an expansion of "global governance" as a response towards various forms of challenges. In particular we are observing processes of searching to establish forms of global political regulation to control the effects of economic dynamics with respect to welfare.

This paper results from some years of discussion in the German Overseas Institute's Research Group on "Globalisation and Social Development" and my own work on "Global Governance" (cf. the Nord-Süd aktuell issue 3/1998; Hein 1998, 1999 2001) and outlines the starting-point of the Group's new Research focus on "Global Health Governance (GHG) and the Interfacing of Global and Local Politics". Our interest focuses on the interaction of global governance and the strategies of nation states in the face of globalisation. Globalisation has not only had important impacts on the systems of health governance (e.g. reforms towards a larger role of the private sector and the rising importance of so-called international public private partnerships in the health sector; the recognition of health as an important "Global Public Good"), but the efforts to fight the growing inequalities in global social development, particularly to move towards the realization of the so-called Millennium Developments Goals (cf. table 1) have led to a perspective on GHG. Health is

increasingly seen not just as a component of development (one of the basic needs). But as a basic pre-condition for economic growth itself (cf. Sachs 2001).

In the first part of this article, I will explain my general starting point for the analysis of the interaction between Global Governance and national politics, then look somewhat closer on the impact of globalisation on health problems in general, and the reaction of nation states to the challenge of reorganizing their health systems in response to changing problems, new developments of global governance in the field of health and, finally, the interfacing of both oriented towards the aim of *improving health as a global public good*.

I will argue, that the new system of Global Health Governance, which has taken shape since the late 1990s, tends to be result-oriented with respect to the improvement of health outcomes at the global scale - in contrast to programmes which basically try to improve health-systems, risking the diversion of resources through corruption and elite-oriented systems. Of course, one has to take into account that middle-income countries with a growing life-expectancy as well as a rather important middle class are more and more confronted with a "double burden", having to react to the increasing importance of non-communicable disease (like cancer and heart-diseases) while they are still fighting with high incidents of infectious diseases and malnutrition (cf. Díaz-Bonilla et.al. 2002 in this issue). ...

In spite of these new challenges, the main indicators for success in developing countries will be - besides child mortality and maternal health - the reduction of victims of infectious diseases, which are strongly associated with poverty, particularly AIDS, TB and Malaria (cf. "goal 6"). Though there is a tendency to re-affirm national ownership of programmes supported, the "result orientation" itself will support a direct link between global funding and field programmes and/or research institutions/ pharmaceutical companies and thus fit into the pattern of "glocalization" which has been observed in many fields of the current globalisation process. If we look e.g. at the Principles of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFFATM) we find this combination of addressing "the nation" on the one hand, but demanding from every nation a certain performance to be in some form controlled by a transnational organisation like the GFFATM: These "principles" include: (a) "The Fund will base its work on programs that **reflect national ownership** and respect country-led formulation and implementation processes", but (b) "The Fund will support

proposals which: ...**Focus on performance** by linking resources to the achievement of clear, measurable and sustainable results. (cf. [globalfundatm.org/principles/html](http://globalfundatm.org/principles/html))."

## (2) Globalisation, National Strategies and Global Governance

Global structures are created and strengthened through the combination of local, regional, national and international societal processes. It would therefore be fair to assume that their development requires an interaction of various means of societal control on different levels of world society, rather than a hierarchic determination of local and national policies by global arrangement. There is no "government" on the global scale, but the term "governance" fits rather well the self-organizing processes of realizing collective goals at the transnational level.

This means, we use "Global governance" basically in the way, it has been defined by James Rosenau, i.e. *"as all the structures and processes necessary to maintaining a modicum of public order and movement toward the realization of collective goals at every level of community throughout the world"* (Rosenau 1997, 363). Global governance is characterized today by a two face structure: its central elements are processes of network-like co-operation of many different actors (International Organizations, Nation States, NGOs, Business Associations, etc.). The other face of global governance is shaped by legally binding agreements of independent nation states. The development of new structures of global governance, then, can be seen as an evolutionary process in which the solutions to new problems arising with the globalisation process are constantly being discussed and "tried out".

The issues of globalization and the role of global governance as well as the reduced effectiveness of political decision-making and -implementation on the national and local level have been analyzed in some detail. Basically we can distinguish three approaches between what might be called a sophisticated international relations approach and a global society approach.

(1) The analysis of international institutions and their transformation into a network of

"global governance" started within the idealist approach of international relation theory. Though it tends to adjust to the growing complexity of international politics., many analyses still primarily look at it from a perspective of nation states which have lost much of their capacity for autonomous policy-making as a consequence of economic globalization. In his 1998 book "Global Public Policy", Wolfgang Reinicke stresses the need for global agreements and rules to reduce the options of economic networks and thus to consolidate the internal operational sovereignty of nation states by "pooling" their sovereignty on the level of global governance. This concept was applied in the UN Vision Project on Global Public Policy Networks (cf. Reinicke et.al. 2000).

"Multilevel governing", which existed before as a problem of coordination between local, provincial and national government, now became a central problem with respect to the interrelation between global governance - or supranational regional communities like the EU - and nation states as the traditional level of sovereign politics. A conceptual approach which might be useful as a starting point for an analysis of the problems concerned has been developed by Fritz W. Scharpf at the MPIfG in Cologne:. Regrettably, however, the use of this approach has been confined strictly to the analysis of the interfaces between national and European politics with the European Union. Nevertheless, there are some categories he proposed which are also useful in our context. Table 2 represents a first attempt to classify elements of Global Health Governance according to Scharpf's table relating policy areas to institutional modes of policy-making (cf. Scharpf 2001, Table 2).

Policy Areas/ Institutional Modes	Market- creating policies	Market- enabling regulations	Process regulations	Welfare state policies	Economic promotion/ protection	Fiscal equalization policies
Supranational			[WTO panels; International Court of Justice]			
Joint decision		Sanitary rules	WHO politics WTO panels	WHO politics WB/IMF, PRSP	WB/IMF, PRSP	[aid]
Intergovernmental	Basic WTO agreements		International many areas	agreements, protocols in [aid]		
Open coordination		Support of DCs institutional capacity		World Economic Forum; World Social Forum, Global Funds with various objectives		
Mutual adjustment		Health system reforms		Health system reforms	Promotion of nat. pharma- industries	

**Table 2: Global Health Governance in a framework of Multi-level Governance**

First, looking at the columns, he distinguishes different policy areas. For the discussion of global governance it is particularly important to look at the differentiation between *market creation* vs. *welfare-state policies* (in an extended meaning). This refers to a general problem in the history of capitalist development: There is a tension inherent in capitalism between "market creation" - and, this implies the aim to attain an optimum of economic regulation through the working of markets - and the guarantee of a certain level of welfare to every single citizen. To a certain degree this tension could be bridged by the fact that an extension of welfare by politics of redistribution did also imply an extension of demand and, thus, in the medium run, as well favoured growth and accumulation through an expansion of markets.

Now, the problem of the actual globalisation process consists in the globalisation of markets while the political mechanisms for welfare politics are still basically confined to the nation state; this implies that the expansion of markets through welfare politics can be captured by producers from other parts of the world and, thus, leading to a crisis of accumulation in the welfare-providing country. The other policy areas, Scharpf refers to, are either related to market creation (market-enabling regulations; process regulations) or to welfare politics in a very broad meaning: including redistribution (economic promotion/protection; fiscal equalization policies)

On the other hand he talks of different "institutional modes" by which he refers to modes of interaction between different levels of governance. Scharpf distinguishes various modes of EU policy-making:

"The *supranational/hierarchical mode*, in which policy choices can be unilaterally imposed by supranational (i.e., the European Court of Justice, ECJ; the Commission; and the European Central Bank, ECB); the *joint-decision mode*, in which supranational actors play a significant role, but cannot act without the acquiescence of at least a qualified majority in the Council of Ministers; and the *intergovernmental mode*, in which policy choices depend solely on the unanimous agreement of member state governments. In addition, I will briefly discuss the new methods of *open coordination* and will also mention the mode of *mutual adjustment* which characterizes national policy processes significantly affected by EU policies or by processes of regulatory and tax competition among EU member states." (Scharpf 2001: 5).

Scharpf primarily looks at the role of the nation state in decision-making at the supranational level. This, of course, constitutes one "direction" of the interfacing between national politics and global governance - but, seen from the perspective of developing countries, the more urgent problem seems to be to look at the interface with respect to the implementation of global governance decisions at the national level: What are the conflicts, what are the adaptive needs which result from demands and offers emanating from global governance being confronted with interests, structures and needs at the local and national level?

The processes of *market creation* are primarily based on intergovernmental agreements (WTO, TRIPS, GATS), but also reinforced by structural adjustment politics which are closer to the "joint decision" mode (significant role of World Bank and IMF, but need for policy-support of national representatives at Annual Conference and formal agreements with countries "to be adjusted). Some elements of "Welfare state politics" can also be grouped in the "joint decision"-category: Day-to-day-policies of international organizations are prepared and negotiated within these organizations or among the officials of various organizations, but they have to be supported by member states during the sessions of the governing bodies. Mutual adjustment, induced by formal structural adjustment politics, but also by mere economic pressures or simply by the search for best practices, is probably the most important factor to lead to changes in national health systems, health insurances, foreign investments in health facilities etc.

Many activities in the field of Global Governance can be seen as activities of "open coordination" where actors of various status associate in different forms to help solving global problems, without being in a position to make binding decisions. Nevertheless, in recent years the leverage of this mode of policy-making has considerably increased because of the participation of powerful actors (e.g. World Economic Forum) and the considerable economic weight of Funds and other forms of public private partnerships. This applies particularly to the case of the GFFATM which might effectively lead to a more important process of economic (and, in effect fiscal) redistribution than conventional aid politics, having raised funds amounting to US\$ 2.113 Bio. within less than a year's time (so far mostly as pledges). The resulting structure of Global Governance coordination, however, has characteristics which are quite different from coordination processes at the EU level, and in effect, is going far beyond of what I called a "sophisticated international relations

approach". This actually leads to the problematique which is analysed in the "architecture of global governance" approach.

(2) An approach concentrating on *the architecture of global governance* (cf. Messner/Nuscheler 1996) looks more into the details of the new forms of global governance. The starting-point is the idea of "governance without government". There are some interesting studies particularly on the relationship between global social movements and global governance (cf. Robert O'Brien et.al., 2000) and the discussion on power relations on the global governance level is intensifying. This relates to the role of dominant nation states in the global governance context, but also to the structural as well as the active political role of Transnational Corporations, e.g. in the context of IPPPs.

The global governance discussion, however, concentrates on the formation of politics on the global level, analysing the outcome of the interactions between different types of actors and of networks on the global level in terms of institutions-building and of politics in specific political fields. There are hardly any studies which centre around the continuous interactive processes between national politics and the major elements of global governance. At the same time one has to take into account that specific aims of global governance particularly in the field of welfare policies do not content themselves with negotiating global regimes as a means of "pooling the sovereignty of nation states" but directly aim at results at the local and individual level (this refers basically to all the Millennium Goals, cf. table 1).

(3) In such a perspective global governance is approaching the idea of *politics in a global society*: The aim is no longer primarily to support the development of national societies/economies and, then, to hope for an improvement of social and health indicators, but to concentrate directly on reducing poverty and poor health. The objectives of *global politics* are no longer restricted to coordinate problems arising at the global level by the interactions between national societies or by private global players and to help national political systems to cope with the effects of globalization but to have an impact at the grass-roots of every national society. And this implies that – at least theoretically – everyone is seen as an actor in global politics. This also implies that the sovereignty of the nation states is by no means any more an unalienable political good; the stereotype of corrupt, self-enriching elites, has become an important argument for political intervention. Ethically, the basic good is more or less the welfare of the individual; pragmatically, however, this is still very much

enmeshed with the concrete problem of the manageability of global affairs.

This, of course, cannot ignore the reality of the national political system being (still?) the basic level of binding political decisions and, of course, that the complexity of “global society” makes it necessary to actively engage local and national political levels into global governance. But, if necessary, *politics in a global society* tries to reach results on the local/individual level by putting pressure on nation states or by luring nation states into specific policies by offering funds which are available under specific conditions. “Welfare” is seen as a global responsibility – in the positive case, the nation state and global governance institutions will cooperate and generate synergy effects, but the global governance level tends to develop the claim of ultimate responsibility in an evolving *global polity* which aims at integration the global governance level with the national and local political levels. This “integration”, however, is *not a harmonious process of cooperation*. The more important the stakes become at the global governance level, the more important power relations at this will become.

In the second part of this contribution, I will go more into details by explaining this concept of "politics in a global society" with respect to the arising new structure of global health governance. Walter Eberlei (2002, in this volume) in his analysis of the Poverty Reduction Strategy process as an expression of global governance will further explore the character of this type of global politics in more detail with respect to poverty reduction.

A better understanding of those processes can only be obtained by identifying the locales of the intersection of different policy levels and by analysing the ongoing interaction between global determinants and national as well as local political processes. This refers to concrete institutions and arenas of political conflict (specific types of negotiations, conferences, parliament, health and finance ministries, campaigns and demonstrations) as well as to processes of the interfacing between policy levels with respect to specific issues (see chapter 5). The forms of interfacing will probably be closely related to the set of institutional modes proposed by Scharpf or maybe lead us to modify it.

New insights in the context of this analysis require empirical investigations, which should concentrate on specific areas, because of the complexity of the globalisation process. The Research Group decided to concentrate on the health sector for the reasons given in the

introduction, but also because it as turned out to be one of the areas most definitely affected by the changing interactions between global governance, national and local policies.

Global health governance in itself is already an extremely complex topic, including very different problems such as for example setting health standards for food (Codex Alimentarius), carrying-through immunization campaigns, informing about and taking measures against epidemics, supporting reforms of national health systems, supporting the provision of primary health care, combating concrete diseases with a global scope. Therefore, the following observations are necessarily very sketchy and just have an introductory character. They should be seen as a starting-point for further discussions and research.

### **(3) Globalisation and National Strategies in the Health Sector: Basic Problems**

Historically, with the development of the modern nation state, the ultimate responsibility for health has become part of national politics. Nevertheless, health sectors in national societies cannot be sufficiently described by government health politics; we always observe an interaction between government, non-governmental organizations (in a large sense, including associations of different kinds), the private sector and individual attitudes (including the ability and the preparedness to pay for health services). The term "health governance" as defined in the paper by Dodgson/Lee/Drager (LSHTM/WHO) seems to offer an appropriate starting-point to analyse the development and dynamics of national health systems: "Health governance concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population." (p.6)

Before the onset of neoliberal globalisation, health governance in most developing countries was in no ways particularly successful (see e.g. World Bank 1993; WHO 2000). During the last decades, however, the rapid globalisation process in interaction with other processes of social change has generated a number of substantial new challenges for the health sectors in Less Developed Countries; reasons are manifold and include: (a) increased costs of health system caused by demographic factors and the potential for improved medical treatment through the spread of new drugs, equipment and methods of treatment developed in the rich countries; (b) changing framework for the development of health systems because of

economic liberalization and deregulation; (c) changes of the legal framework for the organization of the health systems caused especially by the latest developments in the world trade order (especially WTO negotiations generating new rules and regulations of intellectual property rights and patent laws, causing problems of the development of local pharmaceutical industry as well as domestic medical and pharmaceutical research); (d) the increased importance of successful health reforms in other countries as models for own reforms, and (e) an increasing competition with other sectors for scarce public financial resources.

Frequently global governance institutions were seen as responsible for the deterioration of national health systems; politics of *global market-creation* and the destabilization of the institutional structures of the developmental state were in the forefront, welfare-oriented activities more as palliatives. Cooperation in the health sector continued until the 1990s in the traditional form of cooperation with nation states, though, in some aspects the nation state focus was undermined (emergency assistance, vaccination programmes, concept of primary health care, increasing NGO activities).

Increasing global inequalities and problems of poverty, but also a lack of “good governance” at the national level led to the conviction among many actors in Global Health Governance that: (a) welfare problems in developing countries cannot wait until they are solved as a consequence of economic development in these countries, (b) local elite interests are not necessarily compatible with solving national welfare problems, particularly as a consequence of the integration of these countries into the international division of labour (rent-seeking tied to primary exports or particular forms of industrial protection or international capital flows). The central importance of health as one condition of empowerment and the war against poverty – and with it the fight against increased inequality – has become increasingly clear, and with it the need for an international health policy which is more oriented towards poverty.

#### **(4) Globalisation and the Understanding of Health as a Global Public Good**

Conceiving health in this way, finally strengthened the understanding of health as a "global public good". Health has increasingly become a global issue, - because of its vinculation

with poverty, but also a number of other processes:

- We observe a more rapid spread of health problems, as a consequence of an expanding worldwide mobility (infectious diseases) as well as through the spread of consumption habits by global advertising etc.(smoking, changing patterns of food consumption); AIDS was - at least temporarily - seen as a global threat comparable to epidemics like pest and cholera until the 19<sup>th</sup> century and new, hitherto unknown diseases like Ebola were interpreted as the precursors of new global challenges to health care.
- The more rapid spread of drugs and medical technics from rich countries - in principle - to all corners of the earth has the potential to improve global health in general, but also leads increasingly to ethical problems as it makes the selectivity of health services more and more obvious.
- The liberalisation and global regulation of trade decreases the control of national societies over the production of medical drugs, health equipment and - with the General Agreement on Trade in Services (GATS) - to some degree as well over the supply of health services.
- A very disturbing problem constitutes the fact that the defense mechanisms of antibiotics are weakening – because of an over-use by middle- and upper classes and an underutilization by the poorer segments of the population.
- There is of course an increasing concern for the vicious circle of rising poverty and growing vulnerability to health problems in large parts of what is becoming more and more a "global society". Social exclusion has become a problem of health and a starting-point for the spread of epidemics beyond the limits of slums and marginalized societies as well as a serious problem for the provision of health-related services itself..

Health is increasingly considered a “global public good” as it is ever more difficult to control within a local or national area, the development of effective drugs is basically part of a global market and, furthermore, improving health is a precondition for reducing poverty as a global phenomenon (see Chen/ Evans/Cash 2000, Mills 2001). In effect, it was the spread of infectious diseases, which constituted the driving force for the development of some kind of transnational health governance in the 19th century (International Sanitary Conferences etc., cf. Labisch 2002, in this volume). Now, the area of concern is expanding really to the

globe as a consequence of the intensified interconnectedness of global society, which also implies the links between health and other aspects of social development. "Welfare state policies" at least with respect to health are becoming a global concern while in the same time global market-creating policies are reducing the control individual nation states have over the production of health sector inputs - thus changing considerably the framework for the development of health systems in developing countries.

An important milestone in the discussion on "Global Public Goods" has been the UNDP publication by Kaul/Grünberg/Stern in 1999, defining *global public goods* as "...goods whose benefits reach across borders, generations and population groups. All public goods, whether local, national or global, tend to suffer from underprovision. The reason is precisely that they are public. For individual actors, it is often the best and most rational strategy to let others provide the good - and then enjoy it, free of charge. At the international level, this collective action problem is compounded by the gap between externalities that are becoming more and more international in reach, and the fact that the main policy-making unit remains the nation state." (Executive summary on the web-page: [www.undp.org/globalpublicgoods/text/](http://www.undp.org/globalpublicgoods/text/)) .

Being a "public good", of course, does not imply that the state or some kind of public institution necessarily has to supply it, but it means that there is a public responsibility to make sure *that health services are in fact supplied to everyone*. "Health" as a "global public good", thus, does imply two things: a) that it has to be a global concern supporting adequate health services even in the most remote region in the poorest country and b) that if a particular government is not in a position or not willing to provide these services, global governance has to find a way to support adequate health outcomes also in direct cooperation with non-governmental and/or local actors.

Of course, international health politics have a long history. I already referred to the International Sanitary Conferences during the 19<sup>th</sup> century. The WHO has promoted global standards which have gained more and more economic importance in the process of global market-creation (in particular: SPS agreement) and vaccination campaigns to eradicate specific diseases (small-pox, poliomyelitis) (see Loughlin/ Berridge 2002). To a certain degree, the concept of *primary health care* (accepted unanimously with the Declaration of Alma Ata in 1978) can be seen as a forerunner of international concerns for health care at

the local level (see Lachenmann 2002, in this volume). Nevertheless, this did neither lead to a large increase of international funding nor did it imply a sufficient pressure on nation states to comply with the declared political concept.

In several WHO reports, General Director Gro Harlem Brundtland directed the attention towards the "diseases of the poor", basically a number of infectious diseases which are responsible for the largest part of the loss of "disability-adjusted life-years" in poor countries. In 2000 the WHO called for a "massive effort against diseases of poverty", referring to fight against poverty as well to the problem of overcoming antimicrobial resistance (see WHO 2000a). The problem of access to drugs and treatment for the poor and the lack of research in the field of tropical diseases became central topics of international health conference in the last years.

We could observe an increasing importance of NGOs as actors particularly with respect to the health crisis in developing countries as well as an increasing cooperation and networking among international organizations, the most important recent example being the cooperation of various International Organisations under the head of UNAIDS.

There is a growing orientation towards poverty related diseases, basically infectious diseases. This implies a strong focus of international action independent from specific national problems and structures. Of particular importance, however, seem to be a new development in the form of the spread of International Public Private Partnerships in Health (cf. van Ballegoyen 1999; Buse/Walt 2000, 2000a), which received increased attention with organisations like Roll-Back Malaria and Stop TB and which has gained particular prominence with the development of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFFATM), which disposes of unprecedented financial means to be used in the fight against the three diseases (see above).

New and effective drugs have played a central role in this debate because of (1) lack of research in the development of drugs, vaccines and treatment systems with respect to tropical diseases; (2) high costs of existing new drugs which poor developing countries cannot afford; (3) international pharmaceutical companies' interest in the TRIPS agreement as a guarantee for profits through a global recognition of patent rights, including their expectations that resistance in developing countries (and their interest in the clause allowing

"compulsory licensing" in specific circumstances) could be reduced by international funds and differential pricing. In this way, global funds can be seen as forms of expanding the guarantee of global public goods delivery, but also as *market enabling*.

Besides these new developments one should not forget the ongoing activities of WHO and the World Bank, who is still the most important international funder of health projects. (\$ 1.3 bio. *each year* of new projects). Part of this money is supporting health system development; on the other hand, an important part of World Bank lending on health is also supporting the supply and the development of drugs and specific strategies in the field of fighting AIDS, Malaria and Tuberculosis.

#### **(5) Global Governance interfacing with national politics in health**

Even though the development of global health governance is in many ways by-passing national decision-making processes, the concrete delivery of results requires the cooperation with national and local political institutions. The following areas are particularly important with respect to the interaction and interfacing of the different levels of politics concerned:

- (a) *The reform of national health systems and their support by global governance:* Important interfaces are constituted by concrete projects of development cooperation (potential conflicts over expert advice and the transfer of specific models; modalities of financial support) and conflicts over the allocation of public resources and budgetary discipline e. g. with respect to the conditionality in the context of structural adjustment loans.
- (b) *Health problems and issues in the context of tackling poverty:* The most basic interfaces are to be found in the field of coordinating health and income promotion activities, in the Low Income Countries closely related to poverty reduction processes. Furthermore, there might be conflicts over priority setting with respect to resources spent and organisational structures related to primary health care, or the support for the provision of clean water and sanitation on the one hand and the concentration on fighting specific diseases.
- (c) *Impact of trade negotiations and regulations on the health sector:* In the last years main conflicts have been related to the cost of drugs and the acceptance

of TRIPS regulations. In this interfacing process between different actors in national politics, NGOs, national pharmaceutical industries, transnational pharmaceutical companies there are a number of arenas where these conflicts take place (civil society: campaigns and demonstrations, parliaments, diplomacy, international negotiations and conferences); GATS and the offer of medical services by external providers also constitutes a base for interfacing processes between actors and institutions on different levels, particularly with respect to the implied competition for high- and medium income patients between international private and public providers.

- (d) *Influence of national policies (or the lack of it) on global governance processes:* Interfacing processes include the role of national representatives in international organisations and negotiations as well as the role of NGOs, Transnational Companies (which in some institutional contexts have to use *national* governments to support their interests) in negotiations and in IPPPs decision-making. Civil society pressures accompanying international conferences also an arena where actors linked to different levels of GHG are present though frequently these clashes have to be seen as conflicts over the definition of GHG on the global governance level itself. .

Without a successful cooperation at these interfaces between global government institutions and institutions of national and local health governance effective results in improving the health of the poor are not achievable. On the one hand these interfaces are crucial for adapting global cooperation to the specific local circumstances. On the other hand we can expect to find bargaining processes where globgov-institutions are trying to make sure (against specific local elite interests) that their resources are properly used, and local and national institutions insist that financial means are used according to local priorities and not to subsidize pharmaceutical corporations or to spread unrealistic concepts. Thus, these bargaining processes reflect power relations and will not necessarily lead to the best health results - but just because of that it is important to analyse and to understand them.

More research is needed to analyse more closely the conditions international organisations and programmes like the WHO, the World Bank and UNAIDS, but also NGOs and GPPPs (Roll Back Malaria, GFFATM) attach to new forms of expanding global public good delivery in health in their negotiations with nation states. The interfacing of these offers and

conditions with national health systems and local politics trying to guarantee a low-cost supply of health system inputs (particularly through the support of national producers of generics or their imports from low cost producers) on the national level, will be a central focus of the planned research project.

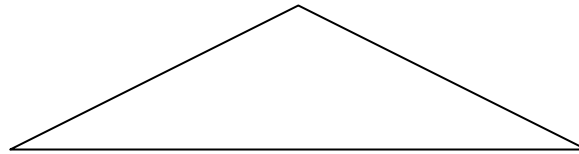
These questions of pushing the development of new drugs and at the same time trying to provide the poor with financial means to buy effective drugs are highly relevant with respect to health sector reforms in the context of an overall market-oriented transformation process. It is an attempt to raise the legitimacy of more market-driven systems by supporting (guaranteeing?) the access to health services and, thus, the necessary demand from the poor.

Though institutions of global governance normally stress the need for national ownership of the programs they support, there is a tendency inbuilt into the arising system of global health governance towards the development of globalized structures, particularly where the support of national structures is conflicting with interests of local actors. Thus, many nation states support the means of compulsory licensing to make cheap drugs available, while pharmaceutical companies supporting GPPPs are trying to prevent undermining the patent system by making funds available for the direct delivery of health services in the context of specific projects.

Nevertheless, the question of using fund money to subsidize the purchase of high-cost pharmaceuticals or to promote the production of cheap generics by pharmaceutical industries in developing countries, points to a *three dimensional conflict*: a) many developing countries and NGOs want to combine the availability of affordable drugs and the support of local pharmaceutical enterprises by finding a way to legalize (within the TRIPS context) the production of cheap generics; b) the profit seeking transnational pharmaceutical corporations insist in upholding their intellectual property rights and high prices for financing research and development; c) in fact, selling e.g. 90% of a specific drug against a tropical disease in the form of generics, which do not take account R&D costs, might leave few incentives for further research in these areas.

## Triangular Conflict:

DCs/ NGOs: Cheap drugs through production of generics in developing countries



Transnational  
Pharmaceutical  
Companies: Profits

Incentives for  
further research

Though the importance of antibiotics and vaccines for the reduction of mortality cannot be denied, of course the access of the poor to medical treatment and other pre-conditions for a healthy life is not guaranteed simply by reducing the costs of drugs. Favoring the development of effective systems of local/national health governance certainly is a point which should not be underestimated because of the actual discourse on the availability of drugs and the focus on AIDS, TB and Malaria. The inclusion of "health" as an important element in the actual Poverty Reduction Strategies does not refer only to ATM. *Health System Development* plays an important role in World Bank and WHO Politics, *primary health* as well within the activities of many NGOs. And finally, though we agree that "health" is a public good in itself, we ought not to forget that, of course, there is a close relationship between overall socio-economic development and the development of an effective health system for all. Thus, even if we will concentrate on the analysis of global-national interfaces with respect to ATM und especially drugs, we have to take account of these broader concerns particularly when trying to understand positions taken by national and local actors.

### (6) Conclusion: Research Needed

Obviously, today the access to drugs and the development of new effective drugs and vaccines, constitutes a central point of Global Health Governance. GPPPs, international governmental organisation in health (WHO, the World Bank), international NGOs, national governments as well as the pharmaceutical industry are intensively discussing problems

related to this. Health economists and other specialists in the field have already engaged in heavy discussions on the priority of push or pull effects for the development of new drugs and vaccines (push R&D to desirable results by direct subsidies or pull them by subsidizing health expenditures of the poor in order to create demand (see Muraskin 2001 summarizing a international colloquium organised by the Albert B. Sabin Vaccion Institute).

I think, from a perspective of health as a *global* public good, we should not take simply for granted that this focus on effective drug development and distribution related to specific diseases will lead necessarily to the right priorities for guaranteeing a universal access to effective health services. They could be simply the result of a specific power constellation in the field of global health governance reacting to specific pressures. It is very important to analyse interfaces between the global, national and local level of health governance and the evolving institutional structure of global health governance with respect to

- a) the interaction of the focus on specific diseases and new forms of raising resources for fighting them with health system development and the concept of primary health care at the national and local levels;
- b) the change of power relations in relation to benefits for the poor, looking at the role of national and local elite interests, but also of global players like transnational pharmaceutical companies in particular and developed countries interests.

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**Table 1: Millennium Development Goals (abbreviated)**

<b>Goals and targets</b>	<b>Indicators</b>
<p><b>Goal 1</b> <b>Eradicate extreme poverty and hunger</b>            Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day</p> <p>Halve, between 1990 and 2015, the proportion of people who suffer from hunger</p>	<ul style="list-style-type: none"> <li>• Proportion of population below \$1 a day</li> <li>• Poverty gap ratio (<i>incidence x depth of poverty</i>)</li> <li>• Share of poorest quintile in national consumption</li> <li>• Prevalence of underweight in children (under five years of age)</li> <li>• Proportion of population below minimum level of dietary energy consumption</li> </ul>
<p><b>Goal 2</b> <b>Achieve universal primary education</b>            Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling</p>	<ul style="list-style-type: none"> <li>• Net enrollment ratio in primary education</li> <li>• Proportion of pupils starting grade 1 who reach grade 5</li> <li>• Literacy rate of 15 to 24-year-olds</li> </ul>
<p><b>Goal 3</b> <b>Promote gender equality and empower women</b>            Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015</p>	<ul style="list-style-type: none"> <li>• Ratio of girls to boys in primary, secondary, and tertiary education</li> <li>• Ratio of literate females to males among 15- to 24-year-olds</li> <li>• Share of women in wage employment in the nonagricultural sector</li> <li>• Proportion of seats held by women in national parliament</li> </ul>
<p><b>Goal 4</b> <b>Reduce child mortality</b>            Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate</p>	<ul style="list-style-type: none"> <li>• Under-five mortality rate</li> <li>• Infant mortality rate</li> <li>• Proportion of one-year-old children immunized against measles</li> </ul>
<p><b>Goal 5</b> <b>Improve maternal health</b>            Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio</p>	<ul style="list-style-type: none"> <li>• Maternal mortality ratio</li> <li>• Proportion of births attended by skilled health personnel</li> </ul>
<p><b>Goal 6</b> <b>Combat HIV/AIDS, malaria, and other diseases</b>            Have halted by 2015 and begun to reverse the spread of HIV/AIDS</p>	<ul style="list-style-type: none"> <li>• HIV prevalence among 15- to 24-year-old pregnant women</li> <li>• Contraceptive prevalence rate <sup>b</sup></li> <li>• Number of children orphaned by HIV/AIDS</li> </ul>

Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

- Prevalence and death rates associated with malaria
- Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures
- Prevalence and death rates associated with tuberculosis
- Proportion of TB cases detected and cured under DOTS

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**Goal 7** Ensure environmental sustainability

**Goal 8** Develop a global partnership for Development