8 Globalizing the policy process

Overview

In this chapter you will learn about the global dimensions of the health policy process. First you will consider why globalization has intensified the need for states and other national level policy actors to cooperate internationally, then identify actors who seek to develop health policies at the global level and those who operate internationally to influence policy at the national health level and finally consider policy transfer between the global and national levels.

Learning objectives

After working through this chapter, you will be better able to:

- **explain what is meant by globalization**
- **appreciate how globalization impacts on health policy**
- **understand why states cooperate to address health problems and why they increasingly do so with non-state actors**
- **identify a range of actors which operate globally in the area of health policy making**

Key terms

Global civil society Civil society groups which are global in their aims, communication or organization.

Global public goods Goods which are undersupplied by markets, inefficiently produced by individual states, and which have benefits which are strongly universal.

Globalization Complex set of processes which increase interconnectedness and inter-dependencies between countries and people.

Introduction

Most of this book has treated policy making in the national context, although one set of contextual factors highlighted in Chapter 1 were those that were described as ‘international’ or ‘global’. International factors were treated as ‘exogenous’ to domestic policy making. With the intensification of global integration, these global factors are playing an increasingly prominent role in national policy making.

Few countries or health policies are immune from global influences. You have seen that health policies, even in high income countries, are subject to pressures from transnational corporations, for example, in relation to second-hand smoke. National policies are also subject to international trade rules, for example, the challenge by the Canadian government of the French ban on the importation of Canadian asbestos on alleged health grounds. High income countries also voluntarily adopt policies so as to coordinate action to address global health threats, for example, on border controls to combat infectious diseases, such as Severe Acute Respiratory Syndrome. Similarly, and arguably to a much greater extent, health policies in low income countries are subject to external forces. Policy conditions may be set by donor organizations on ministries of health in return for access to loans. Policies may also be established in response to pressure from global social movements, for example, South Africa's decision to provide treatment for persons infected with HIV. Moreover, implementation of policies, such as childhood immunization programmes, may be dependent on support from global public–private partnerships such as the Global Alliance for Vaccines and Immunizations. While national policies have always been subject to external influences, globalization has amplified and multiplied them.

For health policy analysts a key question relates to how globalization affects policy making. This can be broken down into three concerns. First, how do global interactions facilitate the transfer of policies among countries and organizations? Second, who influences the transfer of policies? Third, how has globalization shaped the content of health policy? This chapter addresses these questions – but doing so requires that you first have some background knowledge on globalization and an overview of how governments have traditionally cooperated in health.

Globalization

The term globalization is ubiquitous and used in many different ways. Views are polarized on whether or not globalization is a good thing and, because the term is used in different ways, some dispute the very existence of the phenomenon. You can distinguish five ways the term globalization is used. First, globalization is associated with the increasing volume, intensity and extensiveness of cross-border movement of goods, people, ideas, finances, or infectious pathogens (internationalization). Second, globalization sometimes refers to the removal of barriers to trade which have made greater movement possible (liberalization). Alternatively, some associate globalization with the trend towards a homogenization of cultures (universalization) or of a convergence around Western, modern and particularly US values and policies (McDonaldization). While some might rightly question whether or not these trends are new or unprecedented, most agree that they are taking place on a greater scale and with greater intensity than ever before. As a result, there is increasing inter-dependence among countries.

Jan Scholte (2000) argues that what is novel about the contemporary world is the reconfiguration of 'social space' and specifically the emergence of 'supraterritorial' or 'transworld' geography. While 'territorial' space (villages and countries) remains important to people and policy makers, what has changed is that people and organizations have increasing connections to others in ways that transcend territorial

boundaries. For example, people can have loyalties, identities and interests that go beyond an allegiance to the nation–state, linked to values, religion, ethnicity or even sexual identity. Moreover, technologies seemingly compress both time and space. Not only do people and things travel much further, much faster and much more frequently, at times they do so in ways that defy territorial boundaries. Problems can occur everywhere and nowhere. For example, a virus can almost simultaneously infect millions of computers irrespective of their physical location. Millions of currency transactions take place in 'cyberspace' on a daily basis. These examples illustrate a particular dimension of globalization that is new.

Globalization is said to have spatial, temporal and cognitive dimensions (Lee et al. 2002). The spatial dimensions have already been alluded to (we are increasingly 'overcoming' distance) as have the temporal ones (the world has become faster). The cognitive element concerns the thought processes that shape perceptions of events and phenomenon. The spread of communication technologies conditions how ideas, values, beliefs, identities and even interests are produced and reproduced. For some, globalization is producing a global village in which all villagers share aspirations and interests whereas others see Western-inspired values, particularly consumerism and individualism, coming to dominate.

Activity 8.1

Provide an example of the five meanings of globalization.

Feedback

- internationalization – more people flying around the world; the ability to buy 'seasonal' fruits all year around
- liberalization – removal of protection for domestic production of cigarettes
- universalization – same shops and same brand found around the world or the same words used (Internet, STOP)
- McDonaldization – Starbucks in Beijing and Burma
- superterritoriality – buying airline tickets over the Internet from a third country

To fully appreciate the health policy implications of globalization, it is necessary to understand some of the ways that globalization impacts on health.

Globalization and health

The impact of globalization on health is most evident in the area of infectious diseases. Microbes can now find their way to multiple destinations across the world in less than 24 hours. The SARS outbreak in 2003 spread rapidly from China to neighbouring countries and on to places such as Canada. Not only did the virus cause illness and death, it was estimated to have cost Asian economies US$30 billion and the economy of Toronto US$30 million per day at its peak. In 1990, a

ship pumping its bilge in a Peruvian harbour spread cholera throughout Latin America causing 4,000 deaths and 400,000 infections in the first year and considerable costs in terms of lost trade and travel. This was part of the seventh cholera epidemic which spread more quickly than the preceding six. In 2003 and 2004, polio spread from Nigeria to 12 polio-free countries in Central, West and Southern Africa. These outbreaks demonstrate that if an epidemic is not detected or contained by a national health system, it can rapidly become a health threat in other parts of the world because of globalization.

It is not only infectious diseases that benefit from globalization. The global production, distribution and marketing of foods, for example, carry with them health risks linked to unhealthy diets. Behaviours may also be prone to globalization in relation to road traffic accidents, sedentarism, smoking, use of alcohol, the sex trade, and so on. Globalization can also affect the ability of the health care system to respond to health threats. One pressing example relates to health workers. High income countries which cannot meet the demand for health workers domestically tend to recruit workers from poorer countries. The Philippines and India have responded to this global demand by training workers for export. Other countries, such as South Africa and Nigeria, have been losing health workers by default rather than design as they are unable to retain staff due to poor working conditions. As a result of significant global flows of health workers, over 50 countries have shortages of staff which entail that essential health services, such as emergency obstetrics, are not provided.

Activity 8.2

Most health issues and problems are affected in one way or another, often both positively and negatively, by forces associated with globalization. Select a health issue or problem with which you are familiar and attempt to identify the transnational dimensions of the determinants of the problem.

Feedback

You will have first identified the determinants of the health issue. Subsequently, you would need to think about how globalization (in its many guises) may have impacted on the determinant. Take, for example, the incidence of sexually transmitted infections (STIs) in Bangladesh. Arguably, the most important determinants are the position of women, access to treatment for infected persons, and human mobility. Globalization has likely impacted on each of these determinants in different ways. For example, trade liberalization and other factors have resulted in a large movements of workers to and from the Gulf States as well as busy overland trucking routes among India, Bangladesh, Nepal and Burma. This has facilitated a booming sex industry with attendant consequences for STI rates. Trade liberalization and increased foreign investment have resulted in the development of a very large clothing industry in urban areas which has largely employed women. This has improved the bargaining position of women considerably in general and perhaps in relation to sexual relationships which may slow the spread of STIs.

It is important to consider that countries, peoples and problems are differentially integrated. Some countries in Sub-Saharan Africa are not as well integrated into the global economy, for example, as are India and China. Nonetheless, as a result of globalization, most countries will not be able to directly control all the determinants of ill-health and will therefore have to cooperate with other actors outside of their borders to protect the health of those within them.

Traditional inter-state cooperation for health

States have always been concerned about the spread of disease over their borders. For example, as early as the fourteenth century, the city–state of Venice forcibly quarantined ships which were suspected of carrying plague-infected rats. The practice spread to other ports. These early initiatives paved the way for more formal international agreements in the nineteenth century which aimed to control the spread of infectious disease through restrictions on trade. These, in turn, resulted in the International Health Regulations (IHR) which were accepted by all members of WHO in 1969. The regulations provide norms, standards and best practice to prevent the international spread of disease but equally importantly require states to report on a number of infectious diseases. The regulations provide a useful illustration of how states have cooperated to address common problems. The IHR also, however, illustrate the limits of such cooperation. In particular, although states were obliged to report to WHO, many often did not, and there was nothing that WHO could do about the lack of compliance.

States may cooperate in many ways, both formally and informally. You will now learn about the formal arrangements that have been established to facilitate cooperation, focusing particularly on multilateral organizations.

The United Nations

The United Nations (UN) system was established at the end of the Second World War to maintain peace and security and to save further generations from the scourge of war. At the heart of the system was the sovereign nation–state which could take up membership in the various UN organizations (such as WHO, UNICEF). The organizations were established to promote exchange and contact among member states and to cooperate to resolve common problems. Member states dictate the policies of the organizations with little interaction with non-governmental bodies. Thus, within the UN system, governments, particularly governments of high income countries, were able to influence international health policy. Yet, as you will see, UN organizations are also, to varying degrees, able to influence national policy.

WHO was founded in 1948 as the UN's specialized health agency with a mandate to lead and coordinate international health activities. Presently, most nation–states (192) belong to WHO and non-voting 'associate membership' allows 193 NGOs in 'official relations' to participate in the governance of the organization. WHO is governed through the World Health Assembly (WHA). Composed of representatives of member states, typically Ministers of Health, the WHA meets annually to

approve the Organisation's programme and budget and to make international health policy decisions. WHO's Constitution grants the WHA the authority 'to adopt conventions or agreements with respect to any matter within the competence of the Organisation'. Decisions are made on the basis of one vote per member and are binding on all members unless they opt out in writing. The Constitution does not, however, provide for sanctions for failure to comply with regulations. In practice, most of the decisions are expressed as non-binding recommendations, in particular, as technical guidelines, which states may adopt or dismiss depending on their perceived relevance and national politics.

The WHA is advised by an Executive Board which facilitates the work of the Assembly and gives effect to its decisions and policies. The Secretariat is led by an elected Director-General, who is supported by 3,500 experts and support staff working at headquarters in Geneva, in six regional offices and in many country offices. Collectively, they attempt to fulfil the following functions (WHO 2003):

- articulating consistent, ethical and evidence-based policy and advocacy positions
- managing information by assessing trends and comparing performance; setting the agenda for, and stimulating research and development
- catalysing change through technical and policy support, in ways that stimulate cooperation and action and help to build sustainable national and inter-country capacity
- negotiating and sustaining national and global partnerships
- setting, validating, monitoring and pursuing the proper implementation of norms and standards
- stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management, and service delivery

Among these functions, WHO is best respected for the technical norms and standards developed by its extensive networks of experts and its technical advice to members. While WHO may provide the technical basis for health policies around the world, it has virtually no ability to 'impose' these policies on sovereign states – its influence rests on its technical authority.

Other organizations within the UN system also have some responsibility for health. These include the World Bank, the United Nations Children's Fund (UNICEF), the UN Programme on HIV/AIDS (UNAIDS), the UN Development Programme, the Food and Agricultural Organisation (FAO), the World Food Programme and the UN Fund for Drug Abuse and Control. Unsurprisingly, as these organizations matured and grew in size, they began not only to serve their members' needs (i.e. to provide a platform for information sharing and collaboration) but to pursue their own organizational interests in policy debates at both the national and international levels. In this process, UN organizations became actors in their own right; often competing with each other and pursuing different health policy alternatives. For example, the 1980s were marked by a major conflict between WHO and UNICEF over the interpretation of primary health care policy. WHO took the position that a multi-sectoral and preventive approach that improved water and sanitation, literacy, nutrition and was based on mass participation was required to improve health in poor countries. In contrast, UNICEF advocated focusing activity on a few narrow health care interventions that had proved cost-effective and implementing

them through vertical programmes (e.g. childhood immunization). Although this public quarrel was short-lived, it points to differences between organizations over policies which they promote to member states.

Another UN organization with significant influence in health policy is the World Bank. The Bank has a mandate to provide financial capital to assist in the reconstruction and development of member states. Unlike other UN organizations which make decisions on the basis of one country–one vote, voting rights in the World Bank are linked to capital subscriptions of its members. As a result, the Bank has often been perceived as a tool of high income countries. The Bank entered the health field through lending for population programmes in the 1960s, began lending for health services in the 1980s and by the late 1980s led international health policy focusing on financing reforms. By the end of the century, it was the largest external financier of health development in low and middle income countries. Its influence derived not just from the loans it disbursed but also from the perceived neutrality and authority of its economic analysis, and its relationships with powerful finance ministries in borrowing countries. In effect, acceptance of policy conditions associated with health sector loans (which may have been resisted by health officials) could be linked to Bank support for projects in energy or industrial sectors which other ministries cared deeply about. Although the Bank's policies have been contested, most donors, industry and governments have supported them in general.

The World Trade Organisation

The most significant addition to the international architecture emerged in 1995 with the founding of the World Trade Organisation (WTO). The WTO administers and enforces a series of international trade agreements – with the goal of facilitating trade. These global ground rules for trade can impact on health directly through access to medicines, trade in health services or flows of health workers, and indirectly through exposure to consumption and environmental risks that arise from trade. Domestic policies dealing with these issues have become more constrained as a result of the WTO agreements because, by joining the organization, states commit themselves (with no reservations allowed) to alter their policies and statutes to conform with the principles and procedures established in all the WTO agreements.

The WTO Trade Policy Review Body conducts periodic surveys of member government's policies to ensure that they are WTO consistent. Alleged violations can also be notified to the WTO by other member states. Panels of experts review the alleged violations and their decisions, including the need to amend laws to make them WTO-compliant, are binding on member states.

A number of the WTO agreements have implications for health policy. TRIPS, or the Agreement on Trade Related Intellectual Property Rights, has had the highest profile among the treaties in international health policy circles because of its impact on policies concerned with generic drug production and trade. Yet the Agreement on Technical Barriers to Trade, the Agreement on the Application of Sanitary and Phytosanitary Measures, the General Agreement on Trade in Services have all been invoked to challenge the health policies of member states when

other governments fear that they serve to protect domestic industries instead of protecting health.

Bilateral cooperation

Bilateral relationships (that is, government to government) including cooperation and assistance, are as old as the notion of nation–states. Bilateral organizations including the United States Agency for International Development (USAID), the UK Department for International Development (DfID), the Swedish International Development Agency (SIDA), play roles at the international, regional and national levels. They are often major financiers of health programmes in low income countries and of health programmes of UN organizations. Bilateral cooperation often involves a political dimension and these organizations may use their support to pursue a variety of objectives (diplomatic, commercial, strategic) within the UN system and recipient countries. For example, UK bilateral support often favours Britain's ex-colonies; while a large proportion of US bilateral assistance is earmarked for Israel and Egypt, and that of Japan for South-East Asian countries.

Activity 8.3

List five to seven examples of multilateral and bilateral organizations that operate in your own country.

Feedback

Clearly your list will depend on the country chosen but is likely to include several of the UN organizations discussed above.

You have learned that states have a long history of collaboration in relation to health and that they have established a variety of institutions to this end. The impetus for such collaboration has been varied. Some states have clubbed together so as to create global public goods; goods which markets will not produce and governments cannot efficiently produce on their own but have benefits which are universal (e.g. eradicating polio, developing an AIDS vaccine, research on public health issues). At times, cooperation has been more altruistic – perhaps because of shortcomings or lack of resources in other states (e.g. through humanitarian or development cooperation arrangements). Cooperation has also arisen for reasons of enlightened or naked self-interest (e.g. shore up surveillance in low income countries to reduce threat of bio-terrorism in high income ones). At times, 'cooperation' resulting in policy change has been achieved due to threat or coercion, e.g. during 'mopping up' campaigns to achieve universal immunization or as a result of trade sanctions imposed through the WTO regime. Whatever the impetus for interaction, domestic policy processes are not hermetically sealed from international processes; international actors are often actively engaged in national policy making.

Modern cooperation in global health

So far, collaboration has been discussed in the context of formal interaction among states and among states and the international system. Yet, two of the features of the contemporary global health landscape are the emergence of many non-state actors and emergence of policy through informal mechanisms. Both of these developments will now be considered.

Particular emphasis is placed on global civil society, transnational corporations and global public–private partnerships. The aim is to demonstrate that these actors actively participate in international and national health policy processes.

Global civil society

There has been a spectacular proliferation of global civil society groups over the past 50 years; from 1,117 international associations registered with the Union of International Associations in 1956 to over 16,500 in 1998 (UIA 1998). Lester Salamon (1994) argued that a global 'associational revolution' is underway that will be as 'significant to the latter 20th century as the rise of the nation–state was to the latter 19th'.

Global civil society encompasses a diverse set of actors targeting a diverse set of issues. For example, there are global civil society organizations active in:

- reproductive health – such as the International Women's Health Coalition
- trade agreements – such as Health Action International (a coalition of 150 NGOs from 70 countries)
- rights of people with AIDS – for example, the International Community of Women Living with HIV/AIDS which claims to represent 19 million HIV-positive women
- ethical standards in humanitarian relief – for example, the SPHERE Project
- landmines – for example, the International Campaign to Ban Landmines is coordinated by a committee of 13 organizations but bringing together over 1,300 groups from over 90 countries

Global civil society constitutes a heterogeneous lot, from a group of people linked together via the Internet to communicate a shared vision across national frontiers to organizations which have vast amounts of political assets. One civil society organization has eclipsed the World Bank in many important respects as the epicentre of global health. The Bill and Melinda Gates Foundation was established in 2000 and is now a central actor in international health. The Foundation, with an endowment of over US$27 billion (in 2005), disburses over US$500 million per year on health in developing countries.

Although the Foundation is led by Bill Gates Sr. and Patty Stonesifer, and run by a small executive staff, Bill Gates (the world's richest man) and his wife Melinda are actively engaged in the strategic direction of the Foundation and in grant-making operations. They wield considerable influence over health policy and priority setting in international health as a result of the magnitude of resources at the disposal of the Foundation.

The Foundation has played a catalytic role in changing the organizational landscape

in international health. Whereas the other major financier of health development, the World Bank, largely provides loans to governments, the Foundation has mainly supported non-governmental organizations, particularly public–private partnerships with grants. Indeed, one of the most striking features of the Foundation is the number of global public–private partnerships and alliances that it has engineered, incubated and supported financially as well as providing staff to sit on many of their governing bodies. For example, the Foundation played a central role in conceiving the Global Alliance for Vaccines and Immunizations, the Foundation for New Innovative Diagnostics, and the Global Alliance for Improved Nutrition, among others. While the Foundation's support has been critical in financing research, development and product access for a range of neglected conditions, arguably equally important has been its success in getting public and private sector actors to collaborate on policy projects.

The Foundation has been involved in health policy in other ways as well. Through its grant making it has supported evidence-based policy making (see Chapter 9). For example, it has provided US$20 million to help African academies of science to strengthen their ability to provide evidence-based advice to inform government policy making. It has also supported the establishment of a Global Health Policy Research Network whose working groups produce highly influential analytical reports.

Funding provided by the Foundation acts to set priorities in international health by default as governments, non-governmental organizations and international organizations gravitate to where the action is. Moreover, as a result of large investments in international health activities, the Foundation has easy access to influential decision makers at all levels.

Like their national counterparts, civil society organizations play a range of roles in the policy process – either influencing formal international organizations (such as the World Bank) or influencing debates at the national level. They adopt similar strategies: some as insider groups, through global policy communities and issue networks as in the case of Médecins Sans Frontières (MSF) on principles for humanitarian interventions in conflict zones; some as outsider groups which use confrontational tactics such as shareholder activism or organize consumer boycotts against transnational corporations; and some act as thresholder groups which shift between the two positions. For example, MSF was part of a wider issue network working with WHO, UNAIDS and other groups to increase access to HIV/AIDS drugs but was also a member of a network of activist groups using confrontational tactics to lower prices among other demands.

In Chapter 6 you learned that civil society often performs critical roles in the policy process, including participation, representation, and political education and that individual civil society organizations can be identified which motivate (draw attention to new issues), mobilize (build pressure and support), and monitor (assess behaviour of states and corporations and ensure implementation) in respect of particular issues and policies. Partially as a result of improved global communications, global civil society plays the same roles at either the sub-national, national and international levels.

Activity 8.4

As you read the following account of the role of global civil society by Jeff Collin and colleagues (2002), make notes and draw a two- or three-sentence conclusion on the functions it performs at different political levels.

Civil society and the Framework Convention on Tobacco Control

In May 2003 the text of the Framework Convention on Tobacco Control (FCTC) was agreed after almost four years of negotiation by the member states of WHO. The process was highly contested and often polarized with industry pitted against public health activists and scientists and both sides seeking to influence the negotiating position of member states. While the text provides the basis for national legislation among ratifying countries, the process highlights the important role that global civil society can play in international health forums and its limits as well. Interested NGOs with 'consultative status' at WHO participated formally, but in a circumscribed manner (i.e. no voting), in the negotiation process – but were able to use this status to lobby official delegations. Moreover, many NGOs pressed WHO to accelerate the process by which international NGOs enter into official relations with the Organisation – and a decision was made to provide official relations for the purposes of the FCTC process. Second, WHO hosted public hearings in relation to the Convention at which many civil society organizations provided testimony and written statements. Third, civil society groups, such as Campaign for Tobacco Free Kids and ASH, provided an educative function – organizing seminars, preparing briefings for delegates on diverse technical aspects of the Convention, publishing reports on technical issues, and issuing a daily news bulletin on the proceedings. A fourth, and perhaps unique, role involved acting as the public health conscience during the negotiations. For example, some NGOs drew attention to the obstructionist positions of some member states and industry tactics – often in a colorful manner such as awarding an Orchid Award to the delegation that they deemed had made the most positive contribution on the previous day and the Dirty Ashtray award to the most destructive. Fifth, individuals working for civil society organizations were, on some occasions, able to participate directly in the negotiations through their inclusion in national delegations. Over the course of the negotiations, global civil society organizations became a more powerful lobbying force through the formation of a Framework Convention Alliance which sought to improve communication between groups directly involved in systematically outreaching to smaller groups in developing countries. By the end of the negotiations over 180 NGOs from over 70 countries were members. The Alliance thus provided a bridge to national level actions which involved lobbying, letter writing, policy discussions, advocacy campaigns and press conferences before and after meetings.

Feedback

There is general agreement that civil society provided critical inputs into the FCTC process which influenced the content of the Agreement through a variety of approaches. Yet there were limits to its influence. For example, the final negotiations were restricted to member states – thus, effectively restricting the direct inputs of civil society. Perhaps more importantly, the transnational tobacco companies have a larger

amount of political resources that they can deploy to block the implementation of the Convention.

Keck and Sikkink (1998) have drawn attention to the advocacy role that global civil society networks and coalitions play in world politics in diverse areas such as policies on breast milk substitutes and female genital mutilation. Such coalitions aim to change the procedures, policies and behaviour of states and international organizations through persuasion and socialization – by engaging with and becoming members of larger policy community on specific issues. The power of such coalitions stems from their information, ideas and strategies to 'alter the information and value contexts within which states make policies'. In Chapter 6 you learned about the role of advocacy coalitions in altering perceptions of interests through discursive and other tactics in relation to HIV/AIDS. Groups such as the Treatment Action Campaign (largely national) and ACTUP (global) have redefined the agenda and altered the perspectives of corporations (e.g. to lower the cost of drugs, drop lawsuits against governments wanting to implement TRIPS, etc.) and successfully invoked policy responses at the national and international levels (Seckinelgin 2003).

The growth of global civil society has been embraced for a number of reasons. For some it is welcomed due to the declining capacity of some states to manage policy domains – such as health. For others, it is a means to improve the policy process – by bringing new ideas and expertise into the process, by reducing conflict, improving communication or transparency. For others, civil society involvement provides the means to democratize the international system – to give voice to those affected by policy decisions thereby making these policies more responsive. Civil society is also thought to engage people as global citizens and to 'globalize from below'. Others equate civil society as pursuing humane forms of governance; providing a counterweight to the influence of the commercial sector. Despite these promises, there are others who are less sanguine.

Activity 8.5

You have read some of the positive reasons for welcoming the growth of global civil society. What criticisms do you think have been made of global groups?

Feedback

Your list may include:

- *Legitimacy of 'global' groups* may be questioned by North–South imbalances with most funds and members coming from the North and setting the agenda. Fewer than 15 per cent of the NGOs accredited to the UN were based in the South.
- *Concerns about elitism*. While global civil society is often thought to represent the grass roots in practice, some organizations are described as 'astroturf' in that they draw their membership from southern elites.
- *Lack of democratic credentials*. Many organizations have not considered the depth of participation of constituencies nor how to manage consultation.

- *Lack of transparency*. Many groups fail to identify clearly who they are, what their objectives are, where their funds originate, nor how they make decisions. Some are fronts for industry and would be better described as being part of the market.
- *'Uncivil' civil society*. Global civil society is a catch-all phrase for a diverse group of entities. Transborder criminal syndicates and pro-racist groups both have a place in this sector.

Transnational corporations

In Chapter 3 you learned about the heterogeneous character of the commercial sector and the ways that the sector wields influence in domestic health policy debates. The commercial sector, particularly transnational corporations (TNCs), commercial associations and peak associations, also pursue their interests through the international system. In 1998, the Secretary General of the International Chamber of Commerce (ICC) wrote that 'Business believes that the rules of the game for the market economy, previously laid down almost exclusively by national governments, must be applied globally if they are to be effective. For that global framework of rules, business looks to the United Nations and its agencies' (Cattaui 1998). The ICC was particularly interested in the WTO fostering rules for business 'with the proviso that they must pay closer attention to the contribution of business'. The then President made clear that 'We want neither to be the secret girlfriend of the WTO nor should the ICC have to enter the World Trade Organisation through the servants entrance' (Maucher 1998). As a result, the ICC embarked on a systematic dialogue with the UN and a multi-pronged strategy to influence UN decision making – including an overt attempt to agree a framework for such input. The activities resulted in a joint UN–ICC statement on common interests as well as a 'Global Compact' of shared values and principles which linked large TNCs with the UN without the shackles of formal prescriptive rules or a binding legal framework.

While the Global Compact is a highly visible, tangible and controversial expression of the interaction of the commercial sector with the international system, other avenues have also been utilized. The following illustrative list of the ways that the commercial sector exercises its influence in relation to inter-governmental organizations and their work should alert you to the need to include this group of actors in health policy analysis:

- influence on inter-governmental organizations such as WHO, for example, industry roundtables with the Director General, involvement in expert advisory and working groups, staff from industry assume temporary positions; and covert infiltration
- delaying the introduction of international legal instruments
- blocking the adoption of an international instrument, for example, the sugar industry mobilized significant opposition to the international dietary guidelines proposed by FAO/WHO in 2003 (Waxman A 2004)
- influencing the content of international agreements, for example, Philip Morris successfully lobbied the US administration to adopt a particular position on the text of the FCTC (Waxman H 2004)
- challenging the competence and mandate of an international organization to

develop norms in a particular policy area, for example, the food industry opposed and attempted to circumscribe the extent to which WHO can address the obesity epidemic (Waxman 2004)

This list reveals that the commercial sector is actively involved in international organizations – organizations which started life as tools to facilitate inter-country cooperation. The following case study provides an in-depth look at industry involvement in the development of global trade rules.

Activity 8.6

As you read through the case study on intellectual property rights (IPR) consider the following questions, making notes as you go along.

1 Why does industry want binding as opposed to voluntary rules governing IPR?
2 Why does industry seek global rules?
3 Why did the American administration support the Intellectual Property Committee?
4 Why are these trade rules important for public health?

The globalization of intellectual property

Sell (2003) provides a fascinating account of industry influence on the development of an inter-governmental agreement on IPRs that is virtually global in scope. The impetus for global rules arose from the concern among certain industries that weak intellectual property protection outside the US was 'piracy' and represented a huge loss and threat to further investment in knowledge creation. As a result, the Chief Executive Officers (CEO) of 12 US-based TNCs (in chemicals, information, entertainment, and pharmaceuticals) established the Intellectual Property Committee (IPC) to pursue stronger and world-wide protection of IPR. The Committee was formed in 1986, just prior to the launch of the Uruguay Round of trade negotiations which culminated in the establishment of the WTO.

The Committee worked as an informal network. Its goals were to protect IPR through trade law. The Committee began by framing the issue – linking inadequate protection to the US balance of payments deficit. Based on these economic arguments, its considerable technical expertise, and links to administration officials, it was able to win the support of the US administration to its cause. The IPC then set about convincing its industry counterparts in Japan, Canada and Europe of the logic of its strategy (linking IPR to trade law) and gained their support to put the issue on the agenda of the Uruguay negotiations. The IPC commissioned a trade lawyer to draft a treaty which would protect industry interests. This draft was adopted by the US administration as 'reflecting its views' and came to serve as the negotiating document in Uruguay. The IPC was able to position one of its members, the CEO of Pfizer, as an adviser to the US delegation. Although India and Brazil attempted to stall negotiations and to drop IPR from the round, economic sanctions brought them into line. As a result, the Agreement on Trade Related Intellectual Property Rights (TRIPS) emerged and according to industry, 'The IPC got 95% of what it wanted.'

As a WTO agreement, TRIPS has a particularly powerful enforcement mechanism and is likely to have profound implications for public health. The Agreement obliges countries that had hitherto failed to protect product or process patents to make provisions for

doing so and in particular to set the patent period at 20 years. Industry argues that monopoly protection is required to encourage investment in R&D. Critics are concerned that this will place unnecessary restrictions on the use of generic products, inevitably increase drug costs, and erect barriers to scientific innovation.

Feedback

1 Industry wanted binding rules so that all firms would have to comply. Voluntary schemes often result in piecemeal compliance.

2 Industry wanted global rules as they didn't want countries to be allowed to opt out.

3 The US administration is thought to have supported the IPC for a number of reasons. First, the administration accepted the framing of the problem and the magnitude of the problem as estimated by industry. Second, industry provided unique expertise in the area which the US government did not have. Third, these industries provide a great deal of campaign finance and invest heavily in lobbying.

4 The public health impact might be positive and negative. There will likely be more private investment in health R&D. Yet, the availability of these advances might be limited to those able to pay.

As you learned in Chapter 3, the commercial sector influences domestic health policy in a variety of ways and can be a force for positive or negative change. You will recall that the commercial sector also develops private health policy initiatives without the involvement of the public sector. For example, it has developed numerous codes of conduct that are global in scope. Companies also establish alternative mechanisms when public systems fail in ways that affect their profitability. For example, in response to heavy losses incurred as a result of the SARS outbreak in 2003, a group of investment banks, insurance companies and airlines began discussions to establish a fund that would help reduce the risk of global epidemics by strengthening national and global surveillance and response capabilities.

Global public–private health partnerships

One of the features of the globalizing world is the tendency of actors from distinct sectors and levels to work collectively as policy communities and issue networks on policy projects as described in Chapter 6. One of the most visible forms of collaborative efforts (albeit at the formalized end of the spectrum) in the health sector is the multitude of public–private partnerships (PPPs) which have been launched since the mid-1990s. While the PPP label has been applied to wide range of cooperative endeavours, most bring together disparate actors from public, commercial and civil society organizations who agree on shared goals and objectives and commit their organizations (sometimes numbering in the hundreds as is the case with the Global Partnership to Stop TB) to working together to achieve them. Some partnerships develop independent legal identities, such as the International AIDS Vaccine Alliance, whereas others are housed in existing multilateral or non-governmental organizations, such as Roll Back Malaria and the Global Alliance for Vaccines and Immunizations in WHO and UNICEF respectively.

PPPs assume a range of functions. Some undertake R&D for health products, for example, the Medicines for Malaria Venture raises funds from the public sector and foundations which it uses to leverage the involvement of pharmaceutical and biotechnology companies to focus on producing malaria vaccines for use in low income countries. Others aim to increase access to existing products among populations which could otherwise not afford them. The International Trachoma Initiative, for example, channels an antibiotic donated by Pfizer to countries which use it as part of a public health approach to controlling trachoma. A small number of PPPs mobilize and channel funds for specific diseases or interventions, while some operate primarily in advocacy mode, such as the International Partnership for Microbicides. In the course of their work, many PPPs develop policies, norms and standards that may have previously been developed by governments or intergovernmental organizations and most actively seek to set agendas, influence the priority given to health issues, and become involved in policy formulation or implementation by national governments and international organizations.

From a policy perspective, what makes PPPs noteworthy is that fact that they have come to represent important actors in global and national health policy arenas – as even partnerships hosted by other organizations (e.g. STOP TB) will assume distinct identities and pursue specific objectives. Their influence often stems from the range of political resources at their disposal which gives them an edge over organizations working independently or mono-sectorally, for example, political access and savvy, multiple sources of knowledge and perspectives relating to many facets of a policy process, as well as breadth and depth of skills ranging from research capacity to product distribution to marketing techniques. Their power is also a function of their ability to unite a number of important policy actors behind a particular position; actors who may have pursued competing policy alternatives or not been mobilized at all on a particular policy issue. Consequently, PPPs have become powerful advocates for particular health issues and policy responses.

Activity 8.7

Closer relationships between public and private sectors, including through partnerships, while welcomed by most have drawn criticism from some quarters. Write down four or five reasons which may explain critics' misgivings of PPP as they relate to health policy making.

Feedback

Your response may have included any of the following points, most of which are more or less valid at least some of the time:

- PPPs may further fragment the international health architecture and make policy coordination among organizations even more difficult.
- PPPs increase the influence of the private sector in public policy making processes which may result in policies which are beneficial to private interests at the expense of public interests.
- Following on from the previous point, there are concerns that decision making in PPPs

may be subject to conflicts of interest. Although many PPPs develop technical norms and standards, very few have mechanisms for managing real, apparent or potential conflicts of this nature.

- Through association with public sector actors, PPPs may enhance the legitimacy of socially irresponsible companies (what critics term 'blue wash').
- Private involvement may skew priority setting in international health towards issues and interventions which may, from a public health perspective, be questionable. PPPs have tended to be product-focused (often curative) and deal with communicable as opposed to non-communicable diseases. Addressing non-communicable diseases is both more difficult and may directly affect the interests of commercial lobbies (i.e. food and beverage, alcohol).
- PPPs may distort policy agendas at the national level. PPPs behave as other international actors in that they pursue particular policy objectives – they are just another actor.
- Decision making in PPPs is dominated by a northern elite which stands in contrast to decision making in many UN organizations (i.e. one country; one vote). Moreover, representatives from the South tend also to be elites.

Although critics have raised valid concerns about public–private partnerships, in an increasingly integrated world it is natural that policy is increasingly made through policy communities and issue networks. These open up new sites for actors to pursue policy goals and in so doing add further complexity to the health policy arena.

Globalizing the policy process

In Chapter 6, the concept of an 'iron triangle' was introduced – the idea that three broad sets of actors are active in the policy process at the national level (i.e. elected officials, bureaucrats, and non-governmental interest groups – particularly the commercial sector). The changes described in this chapter suggest that policy has an increasing global dimension and specifically that global and international actors often play important roles. Cerny coined the term 'golden pentangles' to reflect these changes to the policy process (2001). While domestic bureaucrats, elected officials and interest groups remain influential, they have been joined on the one hand by formal and institutionalized activities of international organizations (e.g. the World Bank, the World Trade Organisation, the G8, etc.) – the fourth side of the pentangle – and less formal, often networked, entities (e.g. public–private partnerships) and transnational civil society and market activities on the other – the fifth side. Depending on the issue, any or all five categories of actors may be involved and one or more sets may dominate. The image of the pentangle is useful to policy analysts in that it draws attention to the range of interests that may be active and the complexity of any policy process. For governments, particularly those in low and middle income countries, managing this cacophony of inputs in the political system is a difficult business.

Ministries of health in low income countries face an increasing number of actors in the policy process in addition to managing numerous bilateral relationships with diverse donor organizations – often in the context of discrete projects. In the early 1990s it became clear that the demands placed on many ministries by donors who pursued different priorities and demanded separate and parallel project accounting mechanisms were overwhelming and even undermining limited capacity and

making it a challenge to formulate coherent and consistent policy in the sector. As a result, a broad consensus emerged on the need for improved coordination and efforts were placed on establishing 'sector-wide approaches' (SWAPs). These involved articulating an agreed policy framework and medium-term expenditure plan. All external donors were expected to operate within the framework, only to finance activities contained in the plan (preferably through a common pool and ideally intermingled with domestic funds) and to accept consolidated government reports.

Given the politics of development cooperation, success with SWAPs was mixed; many donors continued to fund off-plan, externally designed projects which were poorly harmonized and subject to burdensome and complex reporting and accounting practices – often for purposes of attribution. In countries where progress was made, these gains were often threatened by the arrival of new global public–private partnerships. Many countries now host over 20 health PPPs which often operate as vertical programmes with parallel systems – thus pulling the ministry in differing directions as they compete for attention and priority. As a result, there have been renewed and high profile pleas for coherence at the country level. Similarly, it has been recognized that country-level coordination needs to be supported by global-level coordination. The most prominent manifestation are the Millennium Development Goals (MDGs) agreed in 2000 by 189 countries, with the support of the International Monetary Fund (IMF) and the World Bank, the Organisation for Economic Cooperation and Development (OECD), and the G8 and G20 countries. The eight MDGs have specific targets and include verifiable indicators against which progress is to be measured and to which all actors are to be committed.

Activity 8.8

Why has it been so challenging to coordinate efforts at the country level? Give two or three reasons.

Feedback

Your answer should have discussed the fact that different actors pursue different interests. Often these interests are difficult to reconcile. Bilateral donor organizations may pursue diplomatic or commercial interests in addition to health and humanitarian objectives through development cooperation and these may be at odds with priorities established through a consultative process within another country. As you learned above, international organizations pursue distinct and multiple objectives as well. All organizations, including public–private partnerships, will compete to get their issues onto the policy agenda and to see that they receive attention. Hence, there will always be a political as well as a technical dimension to coordination with external agencies attempting to set agendas and get national counterparts to implement their preferred policy alternatives.

The pentangle model raises questions of whether or not the addition of new categories of actors leads to greater pluralism and whether or not increased interaction

leads to the consideration of a wider range of policy alternatives. There is no one answer to these questions as it will depend on the policy and context. The few empirical studies in the health sector suggest that although some areas have included a greater range of groups, decisions tend to be dominated by communities of policy elites often representing a narrow range of organizations, albeit from public, civic and for-profits sectors (i.e. elite pluralism).

As for the question of whether or not globalization increases the range of policy options under consideration, it would appear that policy agenda setting and formulation are marked by increasing convergence – particularly in relation to the health sector reforms outlined in Chapter 3. Yet the transfer of policies from country to country – often through international intermediaries (such as global partnerships or international organizations) – which results in convergence is not a straightforward process. Explicit cross-border and cross-sector lesson learning (e.g. through study tours) or the provisions of incentives (e.g. loans, grants) does not automatically lead to policy transfer and change. Often the processes are long and drawn out and involve different organizations and networks at various stages.

Summary

In this chapter you have learned that globalization is a multifaceted set of processes that increase integration and inter-dependence among countries. Integration and inter-dependence have given rise to the need for multilayered and multi-sector policy making (above and below the state as well as between public and private sectors). State sovereignty over health has generally, albeit differentially, diminished. Yet the state retains a central regulatory role even if it has to pursue policy through conflict and collaboration with an increasing number of other actors at various levels through policy communities.

References

Cattaui MS (1998). *Business Partnership Forged on a Global Economy*. ICC Press Release. 6 February, 1998. Paris: International Chambers of Commerce

Cerny P (2001). From 'iron triangles' to 'golden pentangles'? Globalizing the policy process. *Global Governance* 7(4): 397–410

Collin J, Lee K and Bissell K (2002). The Framework Convention on Tobacco Control: the politics of global health governance. *Third World Quarterly* 23(2): 265–82

Keck ME and Sikkink KI (1998). *Activists Beyond Borders*. Ithaca, NY: Cornell University Press

Lee K, Fustukian S and Buse K (2002). An introduction to global health policy. In Lee K, Buse K and Fustukian S (eds) *Health Policy in a Globalizing World*. Cambridge: Cambridge University Press, pp. 3–17

Maucher HO (1998). *The Geneva Business Declaration*. Geneva: ICC

Salamon LM (1994). The rise of the non-profit sector. *Foreign Affairs* 73(4): 109–22

Scholte JA (2000). *Globalisation: A Critical Introduction*. Houndsmill: Palgrave

Seckinelgin H (2003). Time to stop and think: HIV/AIDS, global civil society and peoples' politics. In Kaldor M, Anheier HK and Glasius M (eds) *Global Civil Society Yearbook 2003*. Oxford: Oxford University Press, pp. 114–27

Sell S (2003). *Private Power, Public Law: The Globalisation of Intellectual Property*. Cambridge: Cambridge University Press

UIA (1998). *Yearbook of International Associations*. Vol. 1. Organisational descriptions. Union of International Associations. London: UIA

Waxman A (2004). The WHO global strategy on diet, physical activity and health: the controversy on sugar. *Development* 47(2): 75–82

Waxman HA (2004). Politics of international health in the Bush administration. *Development* 47(2): 24–8

WHO (2003). *Overview of WHO*. Geneva: WHO