

MEETING ON GLOBAL HEALTH GOVERNANCE AND ACCOUNTABILITY\*  
2-3 JUNE 2004 HARVARD UNIVERSITY, CAMBRIDGE, MA

CONSTRUCTING GLOBAL PUBLIC HEALTH IN THE 21ST CENTURY\*\*

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*PART ONE: THE CURRENT STATE OF GLOBAL HEALTH*

HEALTH LIES AT THE CORE

Health lies at the very core of modernity and development. It has shaped the nature of the modern nation state and its social institutions. Health has powered social movements, defined rights of citizenship and contributed to the construction of the modern self and its aspirations in the developed world – and is increasingly gaining a similar role in developing countries. Within a very short historical time span of about 100 years, a long and more or less healthy life has become a demographic fact, a societal goal and a personal expectation within developed societies. For many developing countries, the rapid increase in life expectancy has happened in an even shorter time span. Within a time frame of about 50 years, universal access to medical care has become a trademark of industrialized welfare states, and since 1978 – with the Alma Ata Declaration<sup>1</sup> – has been a clarion cry of international health advocates.

The success of public health has changed the very nature of developed societies. They have become *health societies*, defined by five major characteristics:

- a high life expectancy and ageing populations,
- an expansive health and medical care system,
- a rapidly growing private health market,
- health as a dominant theme in social and political discourse and
- health as a major personal goal in life.

Each of these five characteristics, and perhaps even more their synergies, presents a challenge to public health, and changes its nature and the extent of its remit. As in the 19<sup>th</sup> and 20<sup>th</sup> centuries, the resolution that is adopted will define the progress not only for health but also for the economies of 21<sup>st</sup> century society. How will we treat the old? How will we pay for health? Who has a right to care? To what extent will we enhance our biological capabilities? The policy dimensions of these developments are only beginning to be understood in their full economic and social implications, and their impact is no longer limited to the developed world. In an age of interdependence and global movement of goods, services and people, the US\$ 3.8 trillion of health expenditures globally (most of course still in the OECD countries) is a driving force with multiple impacts – the import of health professionals from developing countries, with dire consequences for the countries of origin, being only one example.

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\* The authors would like to acknowledge the Fulbright Institutional Partnerships Grant for funding this project.

\*\* The key arguments in this paper were presented by Ilona Kickbusch in the Hugh R. Leavell Brighton at the World Federation of Public Health Associations' 10th International Congress on Public Health in Brighton, U.K. The lecture, given in April 2004, was entitled "The End of Public Health As We Know It: Constructing Global Health in the 21<sup>st</sup> Century."

The two public health revolutions that changed the face of health and disease in the industrialized countries in the 19<sup>th</sup> and 20<sup>th</sup> centuries, the control of infectious disease through protective health measures and the consequent battle against non-communicable disease, are still underway in differing degrees throughout the world. They are intertwined in new ways in many developing countries that now carry the double burden of disease. A recent report by the World Health Organization (WHO) indicated that the number of deaths from diabetes is 3.2 million deaths per year<sup>2</sup>, which is higher than the 3 million estimated deaths from HIV/AIDS in 2003.<sup>3</sup> People of developing countries are now experiencing what was a key element of the first public health revolution and a consequence of European enlightenment and medical and social progress; it has become clear that health and disease are no longer natural states. Health has become do-able; solutions exist, be they medical, economic or social. With the advent of antiretroviral drugs, for example, HIV/AIDS is no longer a death sentence. With this *do-ability* of treatment arise issues of availability and access for the rich as well as the poor.

At the same time, *do-ability* raises the issue of responsibility and accountability. Just as public health became part of the big social reform project of the first wave of modernity in the developed world – with a focus on the key health determinants of the industrial revolution: water and sanitation, air, housing, education, safe work, better food, shorter work days, maternal care and access to family planning – health is now beginning to play a similar role in the global arena. It is this *do-ability of health* that drives the debate on human dignity, equity and social justice.

#### INTERNATIONAL HEALTH DISPARITIES: THE HEALTH WARS

*“In modernity – so Foucault – the sharpest discourse on difference always takes its starting point from the body.”* These are, as The Lancet editor Richard Horton has said, *“the health wars”*, and we must begin to see them as such.

The post-modern health societies of the developed world stand in stark contrast to the situation in the poorest countries. Particularly in rural areas of poor countries, the predominant pattern is still that of infectious diseases engendered by the natural environment, such as malaria, tuberculosis and infant diarrhea, as well as AIDS and high rates of maternal deaths. As indicated above, non-communicable diseases are also beginning to plague these regions. Poor countries face a stark reality:

- A falling life expectancy in many African countries;
- A lack of access to even the most basic services;
- An excess of personal expenditures for health of the poorest;
- Health as a neglected arena of national and development politics; and
- Health as a matter of survival.

In Africa, only 2 percent of the 4.4 million people who need treatment for HIV/AIDS have access to drug therapy<sup>4</sup>, despite the fall in prices, the creation of UNAIDS and a establishment of the Global Fund on AIDS, Tuberculosis and Malaria. A recent report by the Washington Post on South Africa underlines that *“for a whole generation it is now too late”*.<sup>5</sup> Business opportunities lie in death: spaces for cemeteries, funeral parlors and hearses. But the most worrying dimension of the HIV/AIDS epidemic, according to some South African academics, are its social, economic and political consequences. What impact will the wave of death and dying have on the future of democracy in South Africa? Why was the fight against AIDS not instituted as one of the key initiatives of building a new democracy, as participation in health is often a step towards wider societal involvement?

The comparative statistics for maternal and child mortality for Canada and Haiti, two countries that are just a plane ride away in the same region of the WHO, are striking. According to the Pan-American Health Organization, the infant mortality rate is 5.1 in Canada and 97.1 in Haiti, and the under-5 mortality rate is 16.5 times greater in Haiti than in Canada. The rate of maternal deaths is 35

times higher in Latin America and the Caribbean than in North America. The lifetime risk of death is 1 in 7,700 deliveries in Canada and 1 in 17 in Haiti. Can the world continue to accept these disparities? How can we tolerate a forty-year difference between the average life expectancy in Somalia and in Japan? How should we frame this human neglect in new terms? Would it (in some cases) in an age of the *do-ability of health* qualify as a crime against humanity? We must begin to examine how the responsibility should be divided between the rich and the poor, between the international community and the nation states, the individual citizen and the state, the public and the private sector.

#### HOW COMMITTED IS THE DEVELOPED WORLD?

In an interdependent world, the issue arises as to how much the post-modern societies prepared to share the benefits of the two public health revolutions. Is it acceptable that rich countries share less than 1 percent of their GNP with the world's poor? Why should the life of a citizen in the developed world be worth more than that of an indigenous mother in Bolivia or a young AIDS patient in Zimbabwe? The global health community must determine the steps that need to be undertaken towards a new societal consensus on transfers and solidarity that takes us beyond the nation state, as outlined for example in the International Labor Organization (ILO) Global Campaign on Social Security and Coverage for All<sup>6</sup>.

In the year 2000, the United Nations at its Millennium Summit adopted the Millennium Development Declaration,<sup>7</sup> a set of eight goals to fight global poverty. (See Appendix A.) A recent analysis by the Global Governance Initiative of the World Economic Forum, which brought together leading experts on crucial global governance issues and asked them to focus on these goals, came to the conclusion that "the world is doing barely a third of what is necessary to fulfill the goals it has set."<sup>8</sup> The Initiative gives the world a score of four out of 10 (clearly less than 50 percent) for the direct health-related Millennium Development Goals (MDGs), which aim to accomplish the following by 2015:

- Stop and begin to reverse the spread of HIV/AIDS, tuberculosis and other diseases;
- Reduce by two thirds the under-5 mortality rate; and
- Reduce by three quarters the maternal mortality ratio.

MDG 8, which focuses on *developing a global partnership for development*, is also far from being approached with the necessary effort. Goal 8 includes seven targets that focus on the means to achieve the first seven MDGs. Countries that are poor and heavily indebted need further help in reducing their debt burdens. And all countries would benefit if trade barriers were lowered, thereby allowing a freer exchange of goods and services.

Many of the poorest countries, of course, will need additional assistance and must look to the rich countries to provide it. But what social, political and financial price is the developed world willing to pay for better health both individually and as a community, both at the local and at the global level? Developed nations must reach the target of 0.7 percent of GNP for development aid. Peter Singer, the ethicist, has calculated that it would cost US\$ 100 a year by each citizen in high-income countries for the next 15 years to finance the achievement of the MDGs.<sup>9</sup>

In order to affect change, overseas aid is necessary but totally insufficient. An index developed by the Center for Global Development, called the Commitment to Development Index, ranks 21 of the world's richest countries based on their commitment to policies that benefit the 5 billion people living in poorer nations. The index brings together seven issues: aid, trade, investment, migration, environment, security and technology. Despite the winners and losers, "no wealthy country lives up to its potential to help poor countries. Generosity and leadership remain in short supply."<sup>10</sup>

It is clear that the global community still has far to go to achieve health security and to provide the

poorest people on the globe access to a healthy life. This cannot be achieved by focusing only on diseases, as important as many of the eradication and control initiatives are. It implies that what is desperately needed in the poorest countries is the establishment of strong public health and primary health care systems as well as the development of human resources to deliver these services. More and more, the donors of the big disease initiatives are talking this language. A recent meeting at the WHO of the Interested Parties underlined the need for trained health care workers to ensure the implementation of the many new disease initiatives. The same thinking was echoed in an op-ed of the Washington Post on May 25<sup>th</sup> by Holly Burkhalter, who highlighted the perverse effects and unintended consequences of the influx of money for HIV/AIDS treatment and prevention. Doctors and nurses in Africa are abandoning the public sector in order to pursue internationally funded positions in HIV/AIDS programs. Burkhalter called for Randall Tobias, the United States (U.S.) AIDS czar, to meet the goals of equity and sustainability; for U.S. President George Bush to ask Congress for additional money to build health care infrastructure; and for the U.S. to provide African health workers with health insurance and care, increased salaries, school fees and housing allowances.<sup>11</sup>

Of course it is not only the international community that is at fault. In relation to HIV/AIDS, the report of the Global Governance Initiative puts the blame squarely at the door of *“the lack of support and leadership from the governments of affected countries”*.<sup>12</sup> Amongst the most tragic examples of this statement is South Africa one decade after apartheid and Zimbabwe under the iron grip of the Mugabe regime. This lack of national commitment needs to be the subject of an additional paper. Bad governance in developing countries notwithstanding, there is an overall history of development aid that has contributed to the situation, from the approaches during the cold war, to Bretton Woods recommendations on structural adjustment, to fads and fashions in the development aid business itself that have regularly been inflicted upon poor countries. One of the most telling indicators about development aid gone wrong comes from the recent analysis by the Center for Global Development on the mixture of foreign aid in Tanzania. The small country was forced to coordinate 1,371 different projects funded by international aid agencies between 2000 and 2002.<sup>13</sup>

#### THE EXPANSION OF ACTORS AND TERRITORY IN GLOBAL HEALTH

How can there be a crisis in health? Have we not made systematic progress, as the World Health Report conveys every year? Health issues have increased on agendas at all levels, from the foreign policies of nations to deliberations within the U.N. Security Council and General Assembly. Health has the richest foundation in the world – the Bill and Melinda Gates Foundation – on its side. The contribution to health in international donor aid has increased, particularly through the increased contributions to HIV/AIDS. With WHO, health has an intergovernmental agency that encompasses nearly all countries of the world, a type of institution that many other issue-based groups (such as environmentalists) wish to establish.

Just as the *do-ability of health* is one of the key characteristics of global health development so is its *continuous expansion of actors*. The global health area has been transformed in recent years by a proliferation of actors, as indicated by the growth of civil society organizations (CSOs), the rise of trans national companies (TNCs), and the increasing involvement in health by organizations, such as the World Bank, regional development banks and regional organizations like the European Union. Since the 1980s, United Nations (U.N.) agencies besides WHO, such as UNICEF, UNDP, and UNFPA, have increasingly been dealing with health issues as they converge with their respective mandates. This has been reinforced by a number of U.N. Summits that have included health goals in their major recommendations. New organizations, such as the Joint U.N. Program on HIV/AIDS (UNAIDS) and the Global Fund to Fight AIDS, Tuberculosis and Malaria have been created to take on health matters.

Health has benefited from the many CSOs that are visibly active in the global arena and have put health at the top of the anti-globalization agenda. These organizations participate forcefully in setting global agendas, most prominently in recent years regarding access to antiretroviral drugs for AIDS patients in poor countries. In effect, CSOs have become health policymakers by establishing

codes of conduct, developing social labeling and reporting, and playing the role of watchdogs.<sup>14</sup> Horton asserts, for instance, that Médecins Sans Frontières has replaced WHO at policy development, especially in relation to access to essential medicines.<sup>15</sup>

Health also has a multitude of institutions, partnerships and alliances, and it has spearheaded new ways for the public and private sector to work together. The U.N. Global Compact aims to ensure respect for human rights through the integration of such rights in business operations. Furthermore, U.N. agencies are increasingly involved in health initiatives that are conducted in partnership with many players and organizations. A health program run only by one organization is becoming the exception rather than the norm.

At the same time, there has been a *continuous expansion of the territory of health*. The Alma Ata Declaration opened the door to understand health in the context of development and reinforced the understanding of the first public health revolution that much of the most influential action to create health is found in sectors other than health. The notion of inter-sectoral action was the beginning of a new focus on health determinants. Over the last 20 years, research on socio-economic determinants of health has expanded and reinforced that the health care sector is only one of many sectors (i.e. transportation, housing, education, environment, etc.) that both affect and are affected by health.<sup>16,17,18,19,20</sup> Buse et al. assert, “Where ministries of health and the World Health Organization, largely staffed by medical professionals, once dominated policy-making at the national and international levels respectively, today they are joined by other professionals (e.g. social scientists, trade lawyers, economists, insurance adjusters, information tech specialists) and other institutions. At the national level, policy actors might include other ministries (e.g. trade, finance, foreign affairs, education, transport), NGOs (e.g. Save the Children, Médecins Sans Frontières), foreign aid donors, regional and multilateral development banks, other U.N. organizations (e.g. UNICEF, UNFPA), private companies and industry associations, consultancy firms, charitable foundations, research institutions and criminal organizations.”<sup>21</sup>

Most recently, the Report of the Commission on Macroeconomics and Health, “Macroeconomics and Health: Investing in Health for Economic Development”, underlined that health is a central component of poverty reduction and economic development of nations.<sup>22</sup> It brought the health agenda firmly into the economic development agenda and close to ministries of finance. This was further strengthened by the prominence awarded to health in the Millennium Development Goals.

High profile global health issues have gained visibility through global media. The new Global Media AIDS Initiative, convened by UNAIDS and Kaiser Family Foundation, is helping media companies educate the public on AIDS prevention. Also, global media and the general public have gained interest in global health crises, such as outbreaks of Ebola or SARS. Luckily, and with excellent work done by WHO, these have been contained. However, there is less attention given to the fact that there is also a global health crisis every time that a woman dies unnecessarily in childbirth around the world and every moment a child that could be immunized does not have access to the simplest of prevention measures. There is a global public health crisis every time a sane regulatory approach to tobacco or obesity is defeated in the halls of the WHO because of economic interests. There is a global public health crisis every time a woman has no access to safe contraception or safe abortion or a young man dies of AIDS because he has had no access to life saving drugs. Yet these are quiet crises happening everyday out of sight of media cameras and news reporters.

#### THE PERFECT STORM

The starting point for any serious debate on global health must be that the glass is not half full. It is half empty. Indeed, taking the four out of 10 figure of the Global Governance Report quoted earlier, the glass is *less* than half full. The world is in the midst of a global public health crisis that plays out at all levels of governance but that is not yet understood as a crisis because the do-ability and expansion cover the deeper malaise. A significant weakening of public health has taken place in the

last 30 years throughout the world in both developed and developing countries and in international institutions. Laurie Garrett's excellent book *"The Betrayal of Trust: The Collapse of Global Public Health"* in 2000 was a first clarion cry in this direction but was not heeded to the extent it should have been.

This paper proposes that the global health crisis has six dimensions, which in turn represent the key challenges in health in the world during the next ten years. While each of these dimensions is worrying enough in itself, the synergy between the six dimensions is creating "the perfect storm". The subsequent weakening of public health means that the public health establishment is not well prepared to deal with major seminal trends occurring in relation to health and society. Indeed it raises the issue of to what extent the prevailing structures and policies can respond adequately to a totally new situation.

#### Dimension 1: The growth of epidemics

The growth of epidemics engenders poverty and also negatively affects economic growth and security. All social and economic development efforts manifest themselves in health outcomes, most importantly in better health and life expectancy. Increasingly, it is understood that health, in itself, is an important development factor.<sup>23</sup> The global AIDS epidemic confirms this. Societies that are losing their most productive adult population are also in danger of losing their stability and social cohesion. The disease wipes out individuals in their most productive years, thereby destroying families and yielding parentless generations. National security is endangered by HIV/AIDS, as the virus spreads regardless of national borders and takes the lives of men and women who ensure stability and security: soldiers, policemen, politicians and civil servants. The high rates of HIV infection among teachers and school administrators unravel the progress made toward achieving universal primary education. Deaths among health workers from AIDS only exacerbate the problem, as the demand for health services increases.<sup>24</sup>

No longer is the danger of infectious diseases confined to poor countries, as the Severe Acute Respiratory Syndrome (SARS) epidemic clearly demonstrated. SARS wreaked havoc throughout the world in early 2003. The disease infected 8,422 people in 29 countries and killed approximately 11 percent of those infected. China, Canada, Singapore and Vietnam were those hardest hit. Just 5 months after the first case was reported, WHO brought the SARS outbreak under control by employing centuries-old public health practices. The economic impacts of the short-lived epidemic, however, have been significant. It is estimated that the economic toll of SARS has already reached \$30 billion, largely from canceled travel (thus impacting the service industry and airlines) and decreased investments in Asia.<sup>25</sup>

The developing world is not safe from the health threats of modern lifestyles, as illustrated by the global spread of the tobacco and obesity epidemics. Tobacco is responsible for about 5 million deaths each year, particularly among poor populations and countries. To make matters worse, the total number of people who smoke is increasing. The promulgation of tobacco use has been propelled by a combination of factors, many of which are related to globalization, such as trade liberalization, global marketing, transnational tobacco advertising and the international movement of counterfeit cigarettes.<sup>26</sup> Tobacco manufacturers have located a ripe marketing opportunity in low-income countries as the markets in high-income countries begin to contract.

The obesity epidemic that began in industrialized countries, particularly the U.S., is spreading to low and middle-income nations, especially among the more affluent populations that have the financial resources to adopt Western diets and lifestyles.<sup>27</sup> Key causes of obesity include decreased physical activity and increased consumption of energy-dense foods with high levels of saturated fats and sugar. WHO points to economic growth, modernization, urbanization, and globalization of food markets as some of the factors contributing to the epidemic.<sup>28</sup> U.S. fast food chains, for example, are expanding abroad. Lee observes, "just as working-class parents during the 1950s aspired to eating in

restaurants, people in the developing world accord themselves a certain status and self-esteem by eating in a fast food restaurants.”<sup>29</sup> Unhealthy diets and obesity has contributed to the spread of non-communicable diseases, such as cardiovascular disease, hypertension and stroke, type 2 diabetes and certain types of cancer. Approximately 177 million people are currently living with diabetes, and the number of people with the disease is projected to more than double by 2030, especially in developing nations.<sup>30</sup>

### Dimension 2: The lack of sustainable health systems

The performance of health systems is a crucial component to promoting health and preventing disease. (A health system comprises all organizations, institutions, and resources that produce actions whose primary purpose is to improve health.<sup>31</sup>) Failures of health systems disproportionately impact the poor, as they are given less respect, less choices of providers and lower quality amenities. The poor suffer from a lack of health care coverage and are forced to pay for their treatment, as privatization of health care spreads throughout the world. In India, for example, families pay 80 percent of their health costs out-of-pocket, compared to those in industrialized countries with universal health care pay only 25 percent on average (with the U.S. as an exception, where the average is 56 percent). Private sector provision of health care has grown in part due to lack of funding for public health services. According to WHO, nearly 20 percent of member states spend less than US\$ 15 per capita on health, and health expenditures by the government are often heavily weighted towards tertiary care.<sup>32</sup>

Privatization of health care in many countries has turned health into a commodity that can be bought or sold on the market. In the developed world, this means that citizens become health consumers. In the developing world, it means that the poorest have to use their meager income to access health in the marketplace rather than be supported by a public health system. In countries with high inequalities this leads to many perverse effects, such as using amniocentesis to identify and abort girl children or developing a market for health enhancement while the poorest lack the access to the simplest antibiotics. This close link between health as a product in the face of weak legislation explains why much of the conflict in the international health arena is about the access to drugs, and it indicates that the public health community will need to change its thinking about access to essential medicines in a very basic way. Public health professionals are challenged to protect public health from being subjected to a market model and increasing privatization (directly or through the back door).

Shortages of human resources plague the health systems of the developing world. The lack of health workers is impeding progress towards national health goals and the MDGs, particularly in sub-Saharan Africa. In Botswana, for instance, insufficient health personnel have hindered free distribution of HIV/AIDS drugs. “Brain drain” of health workers is weakening already fragile health systems. Although research on this migration is in its early stages, policy makers have identified it as a key impediment to a well functioning health system.<sup>33</sup> In addition to human resources, health systems are also hindered by insufficient national capacities for public health in both rich and poor countries.

### Dimension 3: The socio-economic-political context

Globalization greatly impacts the socio-economic-political context of health. A number of health concerns have emerged in recent years in debates on globalization. Some of these issues, as outlined by Kelley Lee, include<sup>34</sup>:

- Erosion of national sovereignty and ability of a state to set national health policy and raise funds for health care
- Protection of public health in multilateral trade agreements of the World Trade Organization
- Effects of marketing strategies of TNCs

- Link between widening socioeconomic inequities across countries and effects on the disadvantaged populations
- Changing patterns of health and disease from mobile populations and new patterns of settlement
- Health threat posed by the proliferation of arms trade, biological weapons terrorist activities, illicit drug trafficking, tobacco smuggling and other criminal activities
- Global spread of values, beliefs and practices that affect health
- Changing balance of power among public and private sector actors in health

Globalization, some critics argue, has concentrated political, economic and cultural resources into handful of developed countries. In a recent editorial in *The Lancet*, Navarro asserts that despite this fact, the conflict today is not between developed and developing countries. He argues that famine and poverty in developing nations will not be solved by increased aid and that many impoverished nations (such as Haiti and Bangladesh) have enough resources to feed their populations. The root of the world's health and social problems is, according to Navarro, that the dominant classes in the developed world have allied with the dominant classes in the developing world "who are against a redistribution of resources that would adversely affect their interests."<sup>35</sup> Furthermore, he adds that WHO has been largely influenced by these powerful nations in setting policy agendas.

Analysts warn that we must take control of the effects of globalization rather than continue to consider it a force of nature.<sup>36</sup> More and more, voices are acknowledging that "a fairer world is a safer world."<sup>37</sup> Former U.S. President Bill Clinton was the one of the first leaders to link poverty reduction to counterterrorism efforts.<sup>38</sup> However, the U.S., with its national-interest paradigm, has consistently refused to join international treaties. Indeed, the American agenda seems to be increasingly driving the global agenda. American unilateralism has consequences for all areas of international cooperation, especially health.

At present, the poorest countries are feeling the devastating effects of global health disparities, but there are mounting signals that a new health divide is in the making in the developed world. Indeed, it is becoming increasingly difficult to define the rich and the poor of this world at the level of the nation state, as a large global underclass spreads out around the globe and defies old definitions of vulnerable groups. HIV/AIDS is only the most visible of the diseases of poverty that undermine the life chances of the poor. In a perverse and unintended consequence - as the Global Governance Initiative Report indicates - HIV/AIDS might even divert much needed resources from other diseases of poverty and social problems that otherwise could be addressed efficiently.

Human migration, often spurred by political, social and economic hardships, affects patterns of health and disease. Currently, there are 175 million international migrants in the world, which accounts for 2.9 percent of all people.<sup>39</sup> According to UNHCR, the number displaced people in the world has increased more than fourfold from 5.4 million in 1980<sup>40</sup> to 22.3 million in 2000<sup>41</sup>. While the health problems of refugee populations have been well documented, such as the spread of cholera among Rwandan refugees beginning in 1994, migration has equally severe albeit less dramatic consequences. The spread of HIV, for instance, has been linked to economic migration, as it disrupts social structures and introduces new environmental risks to populations.<sup>42</sup> Vast human migration also places a great burden on national health systems. Also, previously controlled epidemics can re-emerge as health threats.<sup>43</sup>

#### Dimension 4: The values

The value base of global health action has become increasingly vague and unclear. The Health for All orientation of the 1980s was replaced with an investment in health perspective in the 1990s, headed by the World Bank, which brought an economic investment paradigm to the center of the health debate. Since the end of the Cold War, health has become an integral part of the poverty reduction and social safety net strategies of the international community. In paradigmatic terms this means

that the acceptance of health as an end (as reflected in the human rights approach) has been overshadowed by the approach to health as a means.

In consequence, there is a lack of value attached to human lives in poorer nations. Peter Singer compares the very visible crisis of September 11<sup>th</sup> that occurred in the U.S. with the silent crisis of poverty and ill health that occurs every day in poor nations. In response to the terrorist attacks, U.S. citizens donated US\$ 1.3 billion for the victims. Yet on that same day, September 11<sup>th</sup>, 2002, 30,000 children under the age of five died from preventable causes, such as malnutrition, unsafe water and lack of health care. The troubling fact is that this vast amount of children that died that day, about 10 times the number of people on September 11<sup>th</sup>, occurs every day. Although a UNICEF report that was released just two days later stated these figures, there was no appropriate political response.

The global health debate and global health action are heavily influenced by general reorientations in approaches to foreign policy and foreign aid. Conditionalities such as good governance have been introduced. The new Millennium Challenge Account of the U.S., for example, provides assistance to countries based on: 1) their demonstrated commitment to just and democratic governance, 2) level of economic freedom and 3) amount of investments in their people.<sup>44</sup> Furthermore, the U.S. is the only country that has not adopted the WHO resolution on reproductive health at the 2004 World Health Assembly. The “Mexico City” policy that U.S. President Bush reinstated on his first day in office, which prevents U.S. federal funding for international family planning groups that include abortion services, has severely impeded global reproductive health efforts.<sup>45</sup>

The approach of the development community to health is not sufficient, even though it has a clear ethical focus on addressing the health of the poorest. At present, its approach is mainly characterized by a broad mix of strategies, which are steeped in a charity model and loan conditionalities that foster dependency - not a policy model of a global social contract. Despite an ever-growing range of international actors in health and development aid, in the end, it does not work. For example, 140 non-governmental organizations (NGOs) have worked in Haiti; the end result has not been better population health even though each and every one of them was working in good faith in their own little area.<sup>46</sup> William Easterley has provided an excellent analysis of the failures among the development agencies of which he calls “*the cartel of good intentions*”.<sup>47</sup>

There have been new attempts to embark on a debate as to which values should drive global health action. These values are reflected in discussions around the impact of globalization, human rights, global public goods, global solidarity and global social contracts. This is why the debate on new global financing mechanisms is basically one about the values: According to what principles should wealth be shared at the global level? For example, Gordon Brown the British Chancellor of the Exchequer proposed an International Finance Facility, which would double annual aid to poor countries. The Facility is aiming to move to a new premise of financing through collateral bonds issued in the international capital market.

#### Dimension 5: The global actors

The shift from state-centered politics to more complex forms of governance and the increased number of players and collaborative arrangements in global health have led many to believe that there has been a diffusion of power among global health players. The increased interconnectedness between health and non-health actors is blurring their traditional boundaries<sup>48</sup>, and the permeability of national borders has diminished governmental control over a growing number of health determinants.<sup>49</sup> Buse et al. argue that the proliferation of global health actors and partnerships has hindered transparency and accountability. Instability of partnerships can arise when global health actors hold different interests. Current governance structures do not respond to the pluralism in the global health field.<sup>50</sup> This reflects the fact that the new interactions among global health players is transforming the global playing field in health- its norms, rules, practices and, especially, its power politics.<sup>51</sup>

Accountability has emerged as an important issue among global health actors. However, few experts have examined its role in health<sup>52</sup>, and definitions of accountability are often vague. Accountability refers to holding actors responsible for their decisions and actions. Brinkerhoff asserts that answerability is a key component of accountability and outlines three general categories of accountability: financial, performance, and political/democratic. Financial accountability refers to the “tracking and reporting on allocation, disbursement, and utilization of financial resources, using the tools of auditing, budgeting, and accounting.” Next, performance accountability concerns “demonstrating and accounting for performance in light of agreed-upon performance targets” and focuses primarily on services, outputs and results. Finally, political/democratic accountability refers to the “institutions, procedures and mechanisms that ensure that government delivers on electoral promises, fulfills the public trust, aggregates and represents citizens’ interests, and responds to societal needs and concerns.” Elections and the political process, including policy making, are a key mechanism for political/democratic accountability.<sup>53</sup>

Actors in the public, business and civil society sectors differ in to whom they are accountable. First is the public sector, which largely encompasses political/democratic accountability. The accountability of public sector bodies varies according to the level of government. For example, Ministers of Health can be accountable to the government in power as well as the parliament (who are accountable to the citizens). Local government representatives, on the other hand, are accountable to both the central government (for planning and budgeting) and to the people (for meeting their needs and expectations). Also, upon receipt of grants and loans from international donors, governments are accountable to these agencies. And intergovernmental organizations, such as WHO, are accountable to their member states.<sup>54</sup>

Companies, whose role is to generate profit, are first and foremost accountable to their shareholders (which relates particularly to financial and performance accountability). Increasingly, however, progressive thinkers and CSOs are urging that corporate accountability extend to include the “triple bottom line” of financial, social and environmental accounting.<sup>55</sup> As corporate social responsibility spreads, companies are becoming more accountable to society at large, particularly to the communities in which they operate.

Accountability of civil society is more complex. Civil society “facilitates political and social interaction, and mobilizes groups to participate in economic, social and political activities.”<sup>56</sup> When citizens are able to organize into CSOs and voice their concerns, they are better able to hold the public and corporate sectors accountable for their actions.<sup>57</sup> As CSOs have gained in status, their own accountability has become a bigger issue. When delivering services via grants from the government, CSOs are accountable to the government (financial and performance accountability), but if CSOs are concurrently lobbying or lead advocacy efforts, they are also accountable to their constituents/members (political/democratic accountability). This can lead to questions of legitimacy. On the whole, the accountability mechanisms of CSOs are not strong enough.<sup>58</sup>

The globalizing landscape of public health is presenting challenges in accountability. As globalization creates a greater gap between the rulers and their constituents, critics argue, accountability may be reduced.<sup>59</sup> Brugh and Zwi, for example, show that accountability was lacking at national and global levels when the World Bank and USAID pushed for privatization of health care - policy advice that later was regarded as questionable at best.<sup>60</sup> Furthermore, lack of transparency in creating policies only worsens the already inadequate accountability of powerful global organizations.<sup>61</sup> Negotiations at the WTO on public health issues have not been transparent nor have they included the voice of civil society. Instead they have catered to the interests of industrialized nations’ commercial sector. The dispute resolution process, held behind closed doors, has not incorporated the technical expertise of public health experts but instead relied on trade lawyers and diplomats.<sup>62</sup> Finally, global health partnerships also face challenges in accountability because the role and responsibilities of each partner is not always clear.

Inefficiencies of WHO have impeded progress in realm of global health. Health experts have criticized WHO for succumbing to its powerful member states who are dominated by commercial interests.<sup>63,64</sup> For instance, although former WHO Director-General Gro Harlem Brundtland took a strong stand against the tobacco industry, she was more reticent in speaking out against the pharmaceutical industry.<sup>65</sup> Also, some health experts contend that WHO has historically neglected international law.<sup>66</sup> The organization, however, is beginning to make full use of its constitutional powers that allow the organization to form and adopt treaties on health. For the first time in its 36-year history, WHO exercised this power with the development of the Framework Convention on Tobacco Control (FCTC). In addition, WHO's revisions of its International Health Regulations (IHR), one of the two binding resolutions it has adopted<sup>67</sup>, are making them relevant again in the control of the international spread of disease. The IHR modifications were prompted by the global outbreak of SARS.

### Dimension 6: Systems failure

Rich health societies of the 21<sup>st</sup> century have chosen to forget, in a form of collective amnesia, what laid the basis for the health and life expectancy gains in the first and second public health revolutions. In many cases, the development agencies and lending institutions have not been willing to support those very tenants of success in the developing world: a strong state, laws and regulation, public health, public education and the understanding that health is part and parcel of a citizen's right. In the 19<sup>th</sup> century with the social conflict around health and citizen's rights, a new principle entered health governance: the concept of solidarity as an integrative force for both social movements and for identity and cohesion within the nation state. Public health was understood to be a social enterprise.

This collective and societal orientation has been lost frequently in the turmoil of public health practice.

Research has shown that the biomedical model is not sufficient to address all issues related to health, yet, for the most part, the public health community has maintained its disease focus. Geoffrey Rose's public health dictum is truer than ever: "*The primary determinants of disease are mainly economic and social, therefore its remedies must also be economic and social.*"<sup>68</sup> The major reason why this global public health crisis exists today is because the public health community has neglected this dictum.

One element of the systems failure has been society's tendency to be wedded to a *charity model*, which focused on the "deserving" and the "undeserving" poor. "Global health means that the health of the poorest and most vulnerable has direct relevance for all populations because of the many interconnectivities that increasingly bring the world closer. From this perspective, the underlying basis of health sector aid should shift from providing charitable handouts to ensuring appropriate and sufficient resources for a global health system that meets the common needs of the human species."<sup>69</sup> The AIDS epidemic is only the most visible expression of three great failures:

- *the failure to invest in social reform and education,*
- *the failure to build primary health care systems in the developing countries and*
- *the systems failure to continue to be wedded to a global charity model.*

In world of vertical programs and quick fix solutions, societies tend to invest in technologies and drugs and not in social protection, health systems or people. Global policy models for health are often imposed from top-down.<sup>70</sup> Instead of this "cookie-cutter" approach, global health actors need to incorporate local realities and preferences.

Finally, nation states are not giving enough support to the WHO. It is a scandal of global health governance that WHO member states, at present 192 of them, would allow a situation to arise in

which a private philanthropy, the Gates Foundation, has more money to spend on global health than the regular budget of their own organization, the World Health Organization. In a March of Folly, as the historian Barbara Tuchman would say, nation states are giving up their major instrument to drive health policy and ensure health security in an ever more interdependent world. Rather than focusing and pooling sovereignty as would be appropriate in an interdependent world, nation states are cutting up global health responsibility in ever more institutions. They are systematically supporting the *Balkanization*, or fragmentation, of global public health.

Inge Kaul, in her work on Global Public Goods, emphasizes the need to develop a new global policy model. “The pervasiveness of today’s crises suggests that they might all suffer from a common cause, such as a common flaw in policy making, rather than issue specific problems. If so, issue specific responses typical to date, would be insufficient – allowing global crises to persist and even multiply.”<sup>71</sup>

## *PART TWO: STEPS TOWARDS A NEW CONCEPTUAL MAP*

### A NEW CONCEPTUAL MAP

Just a few years ago, Lester Breslow stated that we are now in the midst of the third public health revolution. In his view, the *Ottawa Charter for Health Promotion* is the document that best captures the key characteristic of this new phase of public health, which he terms “health as a resource” and a move towards a new public health. The challenges facing public health today, however, are even larger and more fundamental than Breslow outlined. Public health is at a crossroads. The changes that societies are facing are as significant as the ones encountered in the “golden era” of public health 150 years ago, and they are truly global in nature. In consequence, a new conceptual map is needed for public health action that incorporates, in new ways, scientific and technological development; political, social and economic action; and domestic and global public health responsibilities.

The global public health community must reorient and strengthen public health within both developed and developing societies as a joint endeavor, and institute a resilient system of global governance for health. Failure to do so will lead to dire consequences in terms of human, social and economic development. In view of this reality, Peter Singer, in his Yale lectures on “*One World*”, challenges society to adopt a radically new mind frame of global ethics, global citizenship and global responsibility that goes beyond health as an issue of the nation state and utilitarianism. “Implicit in the idea of ‘globalization’ rather than ‘internationalization’ is the idea that we are moving beyond the era of growing ties between nations and are beginning to contemplate something beyond the existing conception of the nation state.”<sup>72</sup>

The solutions to the crisis in global health go far beyond the expert-based answers, many of which are known. What is needed, in addition to forceful public health action at the nation state level, is a *new global social contract on health*. British Medical Journal’s Editor Richard Smith also made this point in a recent editorial.<sup>73</sup> Public health professionals need to develop support for financing models that are based on rights of global citizens. It was one of the characteristics of modernity to take health out of the confines of religion and charity and make it a key element of state action and the rights of citizenship. This process, initially within the context of the constitution of the nation state, today needs to go global as a key dimension of global justice. The present global drive for access to AIDS medicines for developing nations, for instance, is not just about health. It is the spearhead of a global citizenship movement that has recognized that global health needs to move out of the charity mode into the realm of rights, citizenship and a global contract.

There are many ideas available for such financing models, including the now famous Tobin Tax or George Soros' proposal for issuing special drawing rights. Other ideas include a form of taxation on global consumer goods (such as airline travel and global tourism). Chen et al., for example, proposed that US\$ 1 be charged for each international ticket to go towards a global health security fund or a new form of taxation at the national level where a separate budget is established for the production of global public goods.<sup>74</sup> The International Finance Facility, mentioned above, is an additional viable proposal.

Public health professionals need to instill in politicians and business people that together they need to build a global system of responsibility. This system must ensure access to basic health even where states fail and be linked to a regular flow of funds that is legally binding. Elements of this are part of the Gordon Brown plan. The Global Governance Council and/or the Helsinki Initiative on Global Governance would be fitting initiatives to take this forward.

The world has no choice but to build a global solidarity system as revolutionary as Bismarck's was in his day to share the cost and the risk of global health. Global health leadership needs to develop a social reform model worthy of its historical predecessors but at a global level. The ILO has made a first such attempt with its World Commission on the Social Dimension of Globalization.<sup>75</sup> Health must be placed firmly within such a model and be part of the debate in a much more forceful way than has so far been the case. At last, there are a number of initiatives – for example in Ghana, Kenya and the Philippines – that aim to support developing countries in systematically developing social insurance systems for health rather than keep them dependent on the bi- and multilateral aid flow.<sup>76</sup>

### THE THIRD PUBLIC HEALTH REVOLUTION

The approach to public health must change. The Ottawa Charter spoke of the move towards a new public health and Lester Breslow of the third public health revolution. But this third public health revolution needs to be a global revolution. It is the new interdependence and the new global dynamics that have positioned health as a defining characteristic of the global society of the 21st century.

Just as the Ottawa Charter set out five action areas for the new public health, here are five proposed action areas for the new global public health:

#### 1. Health as a Global Public Good

Population health must, first and foremost, be seen as a global public good (GPG). GPGs are defined as having *non-excludable, non-rival benefits that cut across borders, generations, and populations.*<sup>77</sup> The GPG concept implies that society must ensure the value of health, understand it as a key dimension of global citizenship and keep it high on the global political agenda. It means defining common agendas, increasing the importance of global health treaties and pooling of sovereignty by nation states in the area of health. "The GPG perspective demonstrates that today's global health challenges require not just good national policies, but also strong global responses, the focal point thus being *international collective action.*"<sup>78</sup> This means that all sectors must recognize their interdependencies and work together with accountability and transparency intact.

Public health experts must develop public health models that take radically different approaches and question the very premise of what, at the global level, is a public and what is a private good. Indeed, the global health community must become very Victorian and Bismarckian again and develop a policy and financing model for GPGs that also ensures the rights of global citizens. This means being more challenging and ingenious. And the information technology (IT) sector is a great example. Nicholas Carr has recently questioned the strategic advantage that IT supposedly provides as a proprietary technology. He takes his example from history by outlining how electricity "*became a revolutionary force in society only when it ceased to be a proprietary technology used by one or two*

*factories here and there, and instead became an infrastructure – ubiquitous, and shared by all.....once it became available to all, it became a factor of production.”<sup>79</sup>*

The absence of a global government increases the complexity in providing GPGs, but WHO, as the main global health entity, has a key role to play. WHO must develop a model package of a global health insurance with the insurance industry and, perhaps, the ILO, the ISSA and the World Bank. This model must ensure access to prevention, care and treatment in developing countries; it cannot be piecemeal any longer. Clearly health and social protection cannot be separated. This falls squarely into the Goal 8 on global partnerships of the MDGs. WHO must provide leadership on this issue by attaching greater significance to the concept of population health as a GPG.

WHO must also systematically pursue legislation necessary for GPGs for health as well as the health dimensions of non-health GPGs, like its efforts with FCTC. The organization, for instance, should be a broker in determining political, economic and health implications of policies on intellectual property rights. It is essential that WHO reviews intellectual property laws, patents, etc. that affect public health. National governments should support such efforts. As clearinghouse of information on GPGH, WHO could provide information needed for GPGH, such as surveillance information for the containment of antimicrobial resistance drug resistance.<sup>80</sup>

## 2. Health as a key component of global security

Global integration has proven that disease outbreaks are a threat to international security. Nation states should incorporate health issues into their security strategies. The U.S. Central Intelligence Agency, for instance, now regularly issues a report that draws attention to the impact of disease on political instability, and there is a health advisor in the U.S. State Department.

WHO needs to extend its global health surveillance role and expand its interventionist power in the IHR. WHO member states must also comply with international bodies in reporting potential health threats and should support the financing of a global surveillance infrastructure. Member states should allow WHO to impose sanctions on countries that do not comply through other international bodies, such as WTO or the International Court of Justice. A rapid health response force could be ensured through a new kind of global public goods tax.

Social and economic inequities, including health, must rigorously be addressed at the international level though sustained action on Goal 8 of the MDGs. Rich nations must not only increase their foreign aid to the minimum 0.7 percent GNP, but also reduce poverty via trade, investment, migration, environment, security and technology.

## 3. Strengthening global health governance for interdependence

Health must not only be viewed through the lens of development but also through the reality of interdependence. Strong governance must accompany the changes occurring among global health actors.

Increased accountability among all the sectors would likely lead to improved health outcomes.

Fortifying global health governance for interdependence means, first and foremost, giving WHO a new and stronger mandate. It must have the constitutional capability to ensure agenda coherence in global health (also vis-à-vis the development banks) and be able to strengthen its convening capabilities. WHO should be able to ensure transparency and accountability in global health governance and play a brokering role in relation to the health impacts of policies of other agencies. WHO must make certain that the new collaborative arrangements in global health evolve into networks of governance.<sup>81</sup> One idea is to develop a new kind of reporting system that is requested of all international health actors. The Global Reporting Initiative could serve as a starting point. WHO should also be the coordinator of health in crises by acting as the intermediate health authority.

Indeed, recognition of the organization's coordination and leadership role should significantly reduce the transaction costs for countries and for donors. Finally, it should be explored if WHO should be able to take countries to the international court for crimes against humanity if they clearly refuse to take action based on the best public health evidence and knowledge.

Global health action will need to reach far beyond the ministries of health, and new mechanisms need to be explored to achieve this. In view of the global non-communicable disease epidemics, safety levels with respect to, for example, sugar and salt levels for bottled and tinned goods become as important as safety levels for air and water. As a consequence, action frequently lies with ministries such as consumer affairs, agriculture, industry and commerce. Such action is needed not only at the national but also the international level, given the complex nature of food and agriculture in a global world. Nation states should be supporting WHO in developing a global approach rather than obstructing the road to agreements on global access to safe consumer products.

#### 4. *Accepting health as a key factor of sound business practice and social responsibility*

Increasingly, sound business practice is being understood in terms of corporate citizenship, which makes companies more accountable for public goods- in particular, those that improve health. With the increasing number of corporate scandals and the advent of social reporting that focuses on the triple bottom line, the legitimacy of corporations is more and more becoming more dependent on social responsibility.

Accepting health as a key factor of corporate social responsibility means that businesses must invest in health. Avenues for corporate investment in health can be outlined on four levels, as outlined by the International Business Leaders Forum: workplace, marketplace, community and policy. First, companies must invest in health in the workplace; this spans from ensuring ergonomically correct environments to addressing issues like child labor. At the marketplace level, businesses can promote sustainable development by improving the health impacts of their products and services on their consumers. For example, there is an enormous potential, as the work on nutrition has shown, in producing and marketing health and safety products to the poor. Such new business models should be part of the work of the World Economic Forum. Also, companies can expand the reach of their products and services beyond the traditional consumer base in order to include disadvantaged populations. This means, for example, that as part of corporate citizenship, drug companies should be willing to negotiate the prices of their drugs, thereby increasing the capacity of the WHO to develop a new system of access to drugs based on a global public goods model. In the area of pricing, joint negotiations by 10 Latin American countries (together with PAHO) with global players on antiretroviral drugs led to a 92 percent price reduction.

Third, corporations can invest in health promotion efforts that impact the wider community in order to mitigate health risks for their workers. Companies should consider the health risks facing their employees outside the workplace. ENO, one of the world's major integrated oil and natural gas companies, partnered with WHO in its Roll Back Malaria program to curb illness and deaths due to malaria where it works in Azerbaijan. Finally, at the policy level, corporations can participate in the formulation of public policy that promotes health. Or, alternatively, companies must not seek to foil the developments of public health efforts, especially legally binding global health treaties like the FCTC. Businesses can also form partnerships or become members of business coalitions for health as a strategy to increase corporate citizenship. In addition, businesses can contribute to large funds, such as the Global Fund, and can also work in partnership with development agencies. CEOs can take the lead as key corporate individuals dedicated to a certain health issues, such as Bill Gates, George Soros and Ted Turner.

#### 5. *Accept the ethical principle of health as global citizenship*

Ethical norms must apply to international relations. As inequities in health become more and more obvious, the notion of health as a human right is gaining support. Nigel Dower points out, *“If citizens are increasingly motivated by global concerns then cosmopolitan goals enter domestic policy in that way and people can be effective global citizens by being effective global oriented citizens of their own states.”* In particular, this implies a common notion of social justice and a system of international law where human rights constitute a legal claim. Global health action has begun to expand into the legal territory of rights and global citizenship. The litigation cases against the tobacco companies are a case in point, as is the debate around TRIPS in the WTO. Very important is the push by global social movements that aim to change the rules of globalization and use the most tangible example, the access to HIV/AIDS treatment.

A greater push towards health as global citizenship is essential. Accepting the ethical principle of health as global citizenship requires challenging the dominant neo-liberal paradigm in the world today. “Tension persists between the philosophy of neo-liberalism, emphasizing self-interest of market-based economies, and the philosophy of social justice that sees collective responsibility and benefit as the prime social goal. The practice of public health, with its underlying community and population perspective, sits more comfortably with the latter philosophy.”<sup>82</sup> It is a key responsibility of the public health community to advance this principle of social justice. WHO should establish a UN spokesperson on human rights and health, and CSOs must endorse this notion in their practices.

This year, the 200<sup>th</sup> anniversary of Immanuel Kant’s death, we must remember his words: “to act that you treat humanity whether in your own person or any other person never merely as a means but as an end in itself.” (1785) Immanuel Kant’s thinking leads us beyond the state towards our obligations of citizens in a global world and highlights our obligations to any human being anywhere in the world. Indeed, it is a guiding phrase for the beginning of a new public health revolution.

## CONCLUSION

The positioning of health therefore lies not in the instruments of technical assistance but in the policies of interdependence. This means moving out of the charity model and the focus on the deserving and the undeserving poor as reflected in many of the new modalities and conditionalities of getting access to donor or fund monies. It means first and foremost that the global health community must, on one hand, strengthen international organizations (in particular the WHO) in a way that that allows them to fulfill new functions in an interdependent world and, on the other hand, develop efficient forms of network governance for health. Both strategies must intersect in forms of global accountability and financing that need to be developed and institutionalized.

For WHO this function lies in the policy and normative parts of its Constitution and not in the technical assistance arm it has built up over the years. The issues at stake are binding international treaties for health, not only in the area of disease and medicines but also in such areas as the mobility of health professionals and the brain drain that is hitting developing countries. Health and globalization is not an afterthought but is at the core of this change. The key aim of the global public health community must be to establish health as a right of global citizens and promote global public goods for health. Together with a strategy of empowerment and community involvement such an approach acts as a spearhead to enable and support individual health behaviors.

This means underlining the importance of the state and the public sector; it means translating the do-ability of health into strong public health systems with both a national and a global dimension because they can be separated less and less. Disease maintains poverty and negatively affects

growth and security in both developing and developed societies. Universal access and efficient managing of health care systems are increasingly important components of good governance.

*This shift of perspective is central.*

Amartya Sen has always insisted that the understanding of health as an end (the right of citizenship) is as important as the utilitarian principle of health as a means – and the public health community must never lose sight of the interface between the two.

## *APPENDIX A: MILLENNIUM DEVELOPMENT GOALS*

### GOAL 1 - ERADICATE EXTREME POVERTY AND HUNGER

- Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day
- Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

### GOAL 2 - ACHIEVE UNIVERSAL PRIMARY EDUCATION

- Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

### GOAL 3 - PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

- Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015

### GOAL 4 - REDUCE CHILD MORTALITY

- Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

### GOAL 5 - IMPROVE MATERNAL HEALTH

- Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

### GOAL 6 - COMBAT HIV/AIDS, MALARIA, AND OTHER DISEASES

- Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS
- Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

### GOAL 7 - ENSURE ENVIRONMENTAL SUSTAINABILITY

- Target 9: Integrate the principles of sustainable development into country policies and program and reverse the loss of environmental resources
- Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation
- Target 11: Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers

### GOAL 8 - DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

- Target 12: Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction—both nationally and internationally)
- Target 13: Address the special needs of the least developed countries (includes tariff-and quota-free access for exports enhanced program of debt relief for HIPC and cancellation of official bilateral debt, and more generous ODA for countries committed to poverty reduction)
- Target 14: Address the special needs of landlocked countries and small island developing states (through the Program of Action for the Sustainable Development of Small Island Developing States and 22nd General Assembly provisions)
- Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term
- Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth
- Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries
- Target 18: In cooperation with the private sector, make available the benefits of new

technologies, especially information and communications

## ENDNOTES

- <sup>1</sup> "Declaration of Alma-Ata: International Conference on Primary Health Care," WHO, September 1978.
- <sup>2</sup> "Launch of 'Diabetes Action Now': New estimate of more than three million diabetes-related deaths every year," WHO Press Release, May 5, 2004.
- <sup>3</sup> *AIDS Epidemic Update*. UNAIDS/WHO, December 2003.
- <sup>4</sup> *Treating 3 Million by 2005: Making it Happen*, WHO, 2003.
- <sup>5</sup> Morin, R. "A Wave of Death, Surging Higher: Government Faulted as AIDS Claims Much of a Generation" *Washington Post*, April 1, 2004, p. A.01.
- <sup>6</sup> *Social security: a new consensus*, ILO, 2001.
- <sup>7</sup> A/res/55/2, "United Nations Millennium Declaration", *United Nations*, 2000.
- <sup>8</sup> "Independent Report Gives Failing Grades to Efforts to Improve the State of the World," World Economic Forum press release, January 15, 2004.
- <sup>9</sup> Singer, P. *One World: The Ethics of Globalization*. Yale University Press, New Haven: 2002.
- <sup>10</sup> "Ranking the Rich 2004," *Foreign Policy*, May/June 2004.
- <sup>11</sup> Burkhalter, H. "Misplaced Help in the AIDS Fight," *Washington Post*, May 25, 2004.
- <sup>12</sup> "Global Governance Initiative Executive Summary 2004" *World Economic Forum*, Geneva, p. 14
- <sup>13</sup> "Ranking the Rich 2004," *Foreign Policy*, May/June 2004.
- <sup>14</sup> Buse, K. Drager, N., Fustukian, S., & Lee, K. "Globalisation and health policy: trends and opportunities," in Lee, K., Buse, K., & Fustukian, S. (eds.) *Health Policy in a Globalising World*, Cambridge University Press, Cambridge: 2002.
- <sup>15</sup> Horton, R. *Health Wars: On the Global Front Lines of Modern Medicine*, New York Review Books, New York: 2003.
- <sup>16</sup> Ziglio E., Hagard S., McMahon L., Harvey S., & Levin L. "Investment for Health," WHO, 2002.
- <sup>17</sup> Evans R., Barcer M.L., & Marmot T. (Eds.) *Why are Some People Healthy and Others Not?* Aldine De Gruyter, New York: 1994.
- <sup>18</sup> Wilkinson R.G. & Marmot M. *Social Determinants of Health*. Oxford University Press, New York: 1999.
- <sup>19</sup> Milio N. *Modern Illness, Health Behaviour and Health Policies*. F.A. Davis, Philadelphia: 1981.
- <sup>20</sup> Ziglio E, Levin L, & Bertinato L. "Social and Economic Determinants of Health: Implications for Health Promotion," *Forum Trends in Experimental and Clinical Medicine- suppl. n. (4)*, 1998.
- <sup>21</sup> Buse, K. Drager, N., Fustukian, S., & Lee, K. "Globalisation and health policy: trends and opportunities," in Lee, K., Buse, K., & Fustukian, S. (eds.) *Health Policy in a Globalising World*, Cambridge University Press, Cambridge: 2002, p. 259.
- <sup>22</sup> *Macroeconomics and Health: Investing in Health for Economic Development*, WHO Commission on Macroeconomics and Health, December 2001.
- <sup>23</sup> *Macroeconomics and Health: Investing in Health for Economic Development*, WHO Commission on Macroeconomics and Health, December 2001.
- <sup>24</sup> Kickbusch, I. & Payne, L. "Ensuring Health Security in an Interdependent World" in Drakulich, A. (ed.) *A Global Agenda: Issues Before the 59<sup>th</sup> General Assembly of the United Nations*, UNA-USA, New York: 2004, forthcoming.
- <sup>25</sup> "Severe Acute Respiratory Syndrome (SARS), Report by the Secretariat," *UN Secretariat Report*, January 23, 2004.
- <sup>26</sup> *World Health Report 2003*, WHO, 2003.
- <sup>27</sup> *World Health Report 2001*, WHO, 2001.
- <sup>28</sup> "Obesity and Overweight" WHO Global Strategy on Diet, Physical Activity and Health, WHO, 2003.
- <sup>29</sup> Lee, K. *Globalization and Health: An Introduction*. Palgrave Macmillian, Hampshire: 2003.
- <sup>30</sup> "Diabetes Mellitus Fact Sheet No. 138", WHO website, Retrieved on March 3, 2004 from: <http://www.who.int/mediacentre/factsheets/fs138/en/>
- <sup>31</sup> *Primary Health Care: a framework for future strategic directions*, Geneva, WHO, 2003.
- <sup>32</sup> *World Health Report 2003*, WHO, 2003.
- <sup>33</sup> *World Health Report 2003*.
- <sup>34</sup> Lee, K. *Globalization and Health: An Introduction*. Palgrave Macmillian, Hampshire: 2003.
- <sup>35</sup> Navarro, V. "The World Situation and WHO" *The Lancet*, Vol 363, April 17, 2004, p. 1321.
- <sup>36</sup> Messner, D. "Globalisierung, global governance und entwicklungspolitik," in *Internationale Politik*, 1, S.5-18, 1999.
- <sup>37</sup> McMichael, A., Butler, C., & Ahern, M. "Global Environment," in Smith, R., Beaglehole, R., Woodward, D., & Drager, N. (eds.) *Global public goods for health: Health economic and public health perspectives*, Oxford University Press, Oxford: 2003, p. 106
- <sup>38</sup> Horton, R. *Health Wars: On the Global Front Lines of Modern Medicine*, New York Review Books, New York: 2003.
- <sup>39</sup> *World Migration 2003*, International Organization for Migration, 2003.
- <sup>40</sup> *State of the World's Refugees*, UNHCR, 1998.
- <sup>41</sup> *State of the World's Refugees*, UNHCR, 2000.
- <sup>42</sup> Kickbush, I. & Buse, K. "Global Influences and Global Responses: International Health at the Turn of the Twenty-First Century" in Merson, M., Black, R., Mills, A. (eds.) *International Public Health: Diseases, Programs, Systems, and Policies*. Aspen Publishers, Gaithersburg, MD: 2001.
- <sup>43</sup> *World Migration 2003*, International Organization for Migration, 2003.
- <sup>44</sup> "Report on the Criteria and Methodology for Determining the Eligibility of Candidate Countries for Millennium Challenge Account Assistance in FY 2004 Summary" *Millennium Challenge Corporation website*, Retrieved on May 22 from: [http://www.mca.gov/operations\\_country\\_selection.html](http://www.mca.gov/operations_country_selection.html)

- <sup>45</sup> "Bush Administration's Global Gag Rule Jeopardizing Health Care, Weakening HIV/AIDS Prevention and Endangering Lives" *Population Action International Press Release*, September 24, 2003.
- <sup>46</sup> Oral report on Haiti to the Governing Bodies of PAHO
- <sup>47</sup> Easterly, W. "The Cartel of Good Intentions," *Foreign Policy*, July-August 2002.
- <sup>48</sup> Buse, K. Drager, N., Fustukian, S., & Lee, K. "Globalisation and health policy: trends and opportunities," in Lee, K., Buse, K., & Fustukian, S. (eds.) *Health Policy in a Globalising World*, Cambridge University Press, Cambridge: 2002.
- <sup>49</sup> Jamison D.T., Frenk J., & Knaul F. "International Collective Action in Health: Objectives, Functions, and Rationale" *The Lancet*, 351(9101): 1998, pp. 514-517.
- <sup>50</sup> Buse, K. Drager, N., Fustukian, S., & Lee, K. "Globalisation and health policy: trends and opportunities," in Lee, K., Buse, K., & Fustukian, S. (eds.) *Health Policy in a Globalising World*, Cambridge University Press, Cambridge: 2002.
- <sup>51</sup> Kickbusch, I. "Global Health Governance: Some Theoretical Considerations in a New Political Space" in Lee, K. (ed.) *Health Impacts of Globalization*, Palgrave MacMillian, Hampshire: 2003.
- <sup>52</sup> George, A. "Accountability in Health Services: Transforming Relationships and Contexts" *Harvard Center for Population and Development*, Working Paper Series, Vol. 13, No. 1, February 2003.
- <sup>53</sup> Brinkerhoff, D. "Accountability and Health Systems: Overview, Framework, and Strategies" *Partners for Health Reformplus*, January 2003, p. xi.
- <sup>54</sup> Brinkerhoff, D. "Accountability and Health Systems: Overview, Framework, and Strategies" *Partners for Health Reformplus*, January 2003, p. xi.
- <sup>55</sup> Brinkerhoff, D. "Accountability and Health Systems: Overview, Framework, and Strategies" *Partners for Health Reformplus*, January 2003, p. xi.
- <sup>56</sup> Buse, K. Drager, N., Fustukian, S., & Lee, K. "Globalisation and health policy: trends and opportunities," in Lee, K., Buse, K., & Fustukian, S. (eds.) *Health Policy in a Globalising World*, Cambridge University Press, Cambridge: 2002, p. 260.
- <sup>57</sup> Brinkerhoff, D. "Accountability and Health Systems: Overview, Framework, and Strategies" *Partners for Health Reformplus*, January 2003.
- <sup>58</sup> Zadek, S. "In defense of non-profit accountability" *Ethical Corporation Magazine*, September 2003.
- <sup>59</sup> Buse, K. Drager, N., Fustukian, S., & Lee, K. "Globalisation and health policy: trends and opportunities," in Lee, K., Buse, K., & Fustukian, S. (eds.) *Health Policy in a Globalising World*, Cambridge University Press, Cambridge: 2002.
- <sup>60</sup> Brugha, R. & Zwi, A. "Global approaches to private sector provision: where is the evidence?" in Lee, K., Buse, K., & Fustukian, S. (eds.) *Health Policy in a Globalising World*, Cambridge University Press, Cambridge: 2002.
- <sup>61</sup> Buse, K. Drager, N., Fustukian, S., & Lee, K. "Globalisation and health policy: trends and opportunities," in Lee, K., Buse, K., & Fustukian, S. (eds.) *Health Policy in a Globalising World*, Cambridge University Press, Cambridge: 2002.
- <sup>62</sup> Ranson, M.K., Beaglehole, R., Correa, C., Mizra, Z., Buse, K., & Drager, N. "The public health implications of multilateral trade agreements" in Lee, K., Buse, K., & Fustukian, S. (eds.) *Health Policy in a Globalising World*, Cambridge University Press, Cambridge: 2002.
- <sup>63</sup> Horton, R. *Health Wars: On the Global Front Lines of Modern Medicine*, New York Review Books, New York: 2003.
- <sup>64</sup> Navarro, V. "The World Situation and WHO" *The Lancet*, Vol 363, April 17, 2004, p. 1321.
- <sup>65</sup> Horton, R. *Health Wars: On the Global Front Lines of Modern Medicine*, New York Review Books, New York: 2003.
- <sup>66</sup> Fidler, D. "International Law" in Smith, R., Beaglehole, R., Woodward, D., & Drager, N. (eds.) *Global public goods for health: Health economic and public health perspectives*, Oxford University Press, Oxford: 2003.
- <sup>67</sup> Fidler, D. "International Law" in Smith, R., Beaglehole, R., Woodward, D., & Drager, N. (eds.) *Global public goods for health: Health economic and public health perspectives*, Oxford University Press, Oxford: 2003.
- <sup>68</sup> Rose, G. *The Strategy of Preventive Medicine*. Oxford University Press, Oxford: 1992, p. 129.
- <sup>69</sup> Buse, K. Drager, N., Fustukian, S., & Lee, K. "Globalisation and health policy: trends and opportunities," in Lee, K., Buse, K., & Fustukian, S. (eds.) *Health Policy in a Globalising World*, Cambridge University Press, Cambridge: 2002, p. 277.
- <sup>70</sup> Buse, K. Drager, N., Fustukian, S., & Lee, K. "Globalisation and health policy: trends and opportunities," in Lee, K., Buse, K., & Fustukian, S. (eds.) *Health Policy in a Globalising World*, Cambridge University Press, Cambridge: 2002.
- <sup>71</sup> Kaul, I., Grunberg, I. and Stern, M. (eds.) *Global Public Goods: International Cooperation in the 21st Century*. UNDP, 1999, p. xxi.
- <sup>72</sup> Singer, P. *One World: The Ethics of Globalization*. Yale University Press, New Haven: 2002, p. 8.
- <sup>73</sup> Smith, R., "Towards a Global Social Contract," *British Medical Journal*, April 3, 2004.
- <sup>74</sup> Chen, L., Evans, T., Cash, R. "Health as a Global Public Good," in Kaul, I., Grunberg, I. and Stern, M. (eds.) *Global Public Goods: International Cooperation in the 21st Century*. UNDP, 1999.
- <sup>75</sup> *A Fair Globalization: Creating Opportunities for All*, ILO, February 2004.
- <sup>76</sup> "Social Health Insurance Systems in Developing Countries and Countries in Transition: Advisory Service", *GTZ website*, Retrieved on May 30, 2004 from: <http://www.gtz.de/health-insurance/english/service.htm>
- <sup>77</sup> Kaul, I., Grunberg, I. and Stern, M. (eds.) *Global Public Goods: International Cooperation in the 21st Century*. UNDP, 1999.
- <sup>78</sup> Smith and Beaglehole, p. 271
- <sup>79</sup> Carr, N. "Does IT Matter?" *The Economist*, April 1, 2004.
- <sup>80</sup> Smith, R., Beaglehole, R., Woodward, D., & Drager, N. "Global public goods for health" in Smith, R., Beaglehole, R., Woodward, D., & Drager, N. (eds.) *Global public goods for health: Health economic and public health perspectives*, Oxford University Press, Oxford: 2003, p. 278.
- <sup>81</sup> Kickbusch, I. "The development of international health policies- accountability intact?" *Social Science & Medicine*, Vol. 51, 2000.
- <sup>82</sup> McMichael, T. & Beaglehole, R. "The Global Context for Public Health" in Beaglehole, R. (ed.) *Global Public Health: a new era*, Oxford University Press, Oxford: 2003, p. 10.