Globalization and Health Equity: Innovation for an Interconnected World

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The full report is available at the following site:

http://www.who.int/social_determinants/resources/globlalization_kn_07_2007.pdf

Introduction

Globalisation, in a broad sense, holds considerable potential for improving human health, while presenting many challenges. At base, the key challenge is to understand how globalisation affects people's access to social determinants of health (SDH) and, given an explicit concern with equity, how that access is distributed. The approach taken by the Globalisation Knowledge Network (GKN) to assist with this task emphasized the economic aspects of globalisation since the 1970s on the basis that the policies driving global market integration are the most important with respect to SDH.

There is some evidence of positive global responses to this challenge. Efforts have been made to cut across existing national, international and institutional boundaries to address issues of transnational reach, whether articulated as goals (e.g. the Millennium Development Goals), broadly stated themes (e.g. poverty alleviation, social exclusion, gender empowerment) or control of such health-damaging products as tobacco (e.g. the Framework Convention on Tobacco Control). Even disease-specific global initiatives are increasing their response to the challenge of contemporary globalisation. Efforts to tackle the HIV/AIDS pandemic, as one example, have broadened from an initial biomedical focus to issues concerning human rights, poverty and gender. Yet much more needs to done to manage the multiple ways in which globalisation affects SDH.

Globalisation affects health and SDH through changes in social stratification, differential exposure or vulnerability, health system characteristics and differential consequences. These changes arise through globalisation's effects on power, resources, labour markets, policy space, trade, financial flows (including aid and debt servicing/cancellation), health systems (including health human resources and health services), water and sanitation, food security and access to essential medicines. While not exhaustive, this list covers the principle pathways linking globalisation to health that were examined by the GKN.

Main Findings

1. The economic benefits of recent globalisation have been largely asymmetrical, creating winners, losers and growing inequalities between the two. Globalisation's enlarged and deepened markets reward more efficiently countries that already have productive assets (financial, land, physical, institutional and human capital) than they do countries that lack them (typically low- and some middle-income nations). Globalisation's rules favour the already rich (both countries and people within them) because they have greater resources and power to influence the design of those rules.

2. Global market integration has reduced income inequalities between the world's individuals primarily through poverty reduction in China and, to a lesser extent, India. Income inequalities between countries, and between individuals within countries, however, have risen sharply. Evidence of poverty reduction supports the dominant economic theory which advances that increased global market

integration through trade and financial liberalisation automatically improves growth or reduces poverty. But some of this evidence remains contested, and there is no empirical consensus on liberalisation's relationship to growth or poverty reduction. Further, historic and recent winners from globalisation have not necessarily followed the economic path associated with neoliberal or market-based policies. Much of China's growth-related poverty reduction (which accounts for most of the world's growth-related poverty reduction) occurred before its integration into the global market. Economic growth, in itself, will not improve equity in population health, at least in any acceptable time.

Policy implication: The dominant story of globalisation being a rising tide that lifts all boats is empirically challenged. There is considerable debate remaining over how, and how accurately, the World Bank poverty data ($1/day, $2/day) capture actual poverty trends. Until there is greater evidence-informed consensus on these points, these claims should be treated as hypothetical rather than factual. Limited studies now suggest evidence for an 'ethical poverty line' of between $3 - $4/day, which leads to average life expectancy at birth (LEB) of between 70 and 74 years. This has enormous significance with respect to the Millennium Development Goal poverty reduction target, aid and debt cancellation policies, trade and investment policies and global taxation/redistribution policies.

Research challenge: Comparative studies are needed of the combination of global rules and domestic policies under which international economic relations can achieve the fastest possible eradication of poverty within global environmental constraints on overall consumption. Additional study is also needed to confirm initial findings on the 'ethical poverty line,' and to work through the policy implications, as well as research on how to enhance the uptake and utilization of the concept by various global stakeholders (i.e. governments, multilaterals, international NGOs).

3. The past 25 years of intensified global market integration have seen a slowdown or reversal in health improvements, and growing health inequalities. A regression analysis commissioned by the GKN found that, compared to a continuation of trends over the 1960 – 1980 period, globalisation policy-driven changes reduced potential gains in life expectancy at birth (LEB) by 1.53 years, due primarily to increases in income inequalities. Sub-Saharan African and Latin American countries, the former USSR and countries in economic transition suffered the greatest LEB losses. Even incorporating gains due to improved health technology, potential worldwide LEB gains still fell by 0.13 years since 1980. While much of the reversal in LEB in sub-Saharan Africa is a result of HIV/AIDS, the high prevalence in many sub-Saharan African countries is partly attributable to globalisation policies associated with debt crises, capital flight and structural adjustment programmes. In the former USSR, much of the reversal in LEB is due to the collapse of public institutions and safety nets.

4. Globalisation is leading to the gradual emergence of a genuinely global labour market wherein inequalities between skilled and unskilled workers are

increasing, both within and across national borders. Global economic integration and the expansion of the global labour force are also combining to generate increased pressures for labour market 'flexibility,' with negative effects on economic security for many workers.

Research challenge: The relative roles of trade liberalisation and technical innovation (capital intensive vs. labour intensive production) associated with liberalisation of capital flows in increasing labour market insecurities is not known. The threat of 'outsourcing' to lower wage countries is being used to suppress labour costs in higher-income countries, but there is disagreement on the amount of job loss and job-restructuring (e.g. 'casualization') that outsourcing actually creates.

5. Men and women experience globalisation's effects on labour markets differently. In general, globalisation has been accompanied by the reproduction of gender hierarchies, as women tend to occupy lower paid, less desirable jobs while continuing to bear a disproportionate share of responsibility for unpaid work in the household. While increased women's employment, notably in export-processing zones, has contributed to gender empowerment, exploitative and unsafe conditions and lack of labour rights in many such zones compromise any potential health gains. A further manifestation of gender hierarchies is the emergence of a global political economy of care work, overwhelmingly done by women. One of the most important barriers to women's ability to participate as full economic actors in the global economy is their domestic responsibilities and, for a large subgroup, their childcare responsibilities. These responsibilities, in turn, and the lower pay accorded women workers throughout the world, reflect deeply entrenched patterns of gender discrimination.

   Policy implication: National policy priority should be given to providing all women with access to child care, free or at minimal cost, through the appropriate combination of labour standards and direct public expenditure by national governments and development assistance providers.

   Research challenge: Analyses of the impacts of consumer boycotts, civil society mobilisation/campaigns and specific government responses (e.g. the US proposed anti-sweatshop legislation, UK probes of role of purchasers in forcing developing country suppliers in breaking their own voluntary agreements on ethical trade) on improving working conditions, labour rights and gender equity in developing country export factories/export processing zones.

6. Among the key objectives of economic policy should be the creation of an economic environment which generates livelihoods for all people, providing stable incomes at a level consistent with their physical, mental and social well-being; and social protection for those unable to attain or sustain such a livelihood. This will mean bringing employment back in as a central concern of economic and development policy. Adoption and effective implementation of the International Labour Organisation's four core labour standards (which address free association, collective bargaining, elimination of economic

discrimination by gender, and the elimination of forced labour) must be a priority of all national governments and multilateral institutions. Some evidence suggests that this process is facilitated, rather than hindered, by economic openness, although caution is in order about the extent of effective implementation.

Research challenge: Open economies tend to report less specific violation of the four core labour rights than do closed economies; but the increased power of capital over labour that has accompanied globalisation's market integration may give workers' considerably less bargaining power to exercise these rights. It is important to understand whether globalisation, while increasing these rights *de jure*, is decreasing their exercise *de facto*.

7. Global market integration is shrinking national policy space. For purposes of the GKN, policy space is defined by the extent to which national decision-making for health and SDH can be made without subordination to priorities such as economic growth, maintaining payments to external creditors or complying with trade agreement disciplines, to the extent this creates health-negative effects. The fact that policy space is available to governments does not necessarily mean that it will be used. Some restrictions on national policy space can be health-positive, as is the case of the international framework for human rights and global labour conventions.

   Policy implication: From a vantage of increasing global health equity, it is important to distinguish between supranational agreements that constrain domestic policy space in health positive ways (e.g. human rights, environmental accords) from those that reduce policy space in health negative ways (e.g. some trade agreements, explicit conditionalities of the international financial institutions, implicit conditionalities of international financial markets).

   Research challenge: Development of mechanisms to ensure prioritisation of health-positive over health-negative supranational agreements, in the absence of effective sanctions at the global level, when, for example, economic agreements are backed by trade sanctions (WTO) or withholding of funds by national governments.

8. Trade agreements are one aspect of globalisation that limits the range of policy instruments available to governments; that is their intent. Health concerns need to gain more ground as part of trade negotiations.

   Policy implication: To preserve national policy space for health and SDH, governments have to put particular emphasis on the rule-setting part of trade negotiations in sectors, such as intellectual property rights, health and health-related services, domestic regulation, government procurement, tariff reduction and domestic economic subsidies. Governments should explicitly ensure that national health and SDH priorities are not negatively affected by trade and economic policy choices. This requires building up their capacity for analyzing trade policy impacts and ensuring that health ministries are better able to

articulate their views during agenda setting for trade negotiations. The rapid growth in bilateral and regional free trade agreements (many of which are 'WTO-plus') is worrying in regard to the policy capacities of many developing countries. WHO should ensure that it has sufficient capacity and expertise, including legal expertise, to provide Member States with technical guidance and support on how they can maintain policy space for health in existing or new trade treaties.

Research challenge: Claims that trade liberalisation improves growth, reduces poverty, increases revenues for health investment and so improves health continue to be empirically and theoretically challenged. Given the increasing centrality of these justifications for deepening global market integration, more investigation of these claims is urgently needed, with appropriate differentiation between country circumstances and product types.

9. The ease and speed with which large-scale investors can shift funds around the world in response to the prospect of economic instability or higher taxation also reduces policy space. Even governments with strong commitments to egalitarian domestic policy directions may have to temper these commitments in order to maintain their credibility with international financial markets. The ease of capital flight further offers the rich a powerful source of influence on domestic policy.

    Policy implication: A key area for action by the international community involves changes in mechanisms of global governance over what might be called the international architecture of economic power.

    Research challenge: Review of possible reforms of global financial markets/rules was not undertaken by the GKN; a study of such reforms with the policy goal of reducing global health inequities is needed.

10. Trade and financial market liberalisation, even if potentially bringing growth-related health benefits, poses specific risks. The weight of evidence in the existing literature finds that trade liberalisation and openness increase economic insecurity, although there is not consensus on this point. There is greater research consensus that financial liberalisation and the movement of capital is a more important determinant of economic instability than trade openness.

    Policy implication: Careful design and sequencing of liberalisation commitments together with expanded social protection policies (notably but not exclusively health insurance) can buffer some of liberalisation's health-negative consequences. Such policies should be universal and progressively tax-funded whenever possible (to maximize risk-pooling equity and efficiency) and not tied to employment, since many of the world's poorer workers are in the informal economy or lack access to employment-based social insurance schemes.

11. Declines in public revenues from tariffs reductions hurt many low-income countries, indicating a need to develop alternative and equitable forms of public revenue collection in advance of further tariffs cuts. High-income countries with such systems should assist low-income countries in developing the institutional capacities for progressive forms of revenue collection.

    Policy implication: High- and middle-income countries with already diversified systems of taxation (hence less reliance on tariffs) should not demand further tariffs reductions in bilateral, regional and world trade agreement negotiations with low-income countries still reliant on such tariffs for public revenue, at least until these countries are able to develop alternative methods of revenue collection and the institutional capacity to sustain them. Developing these methods further requires multilateral efforts to reduce the revenue constraints imposed by tax competition that arises from increased trade and financial market liberalisation.

    Research challenge: Ongoing study/monitoring of improved systems of taxation in LMICs supportive of the goal of increasing global health equity. Such studies would include *inter alia* equity, efficiency and effectiveness comparisons of income vs. consumption taxes (especially in countries where most employment income is generated informally and is more difficult to tax), payroll taxes, etc. There is also a need for studies of the costs of different forms of tax competition, optimal mechanisms for controlling such competition, and the extent and distribution of the benefits of doing so.

12. Increased global trade in food products is associated with a nutrition transition in low- and middle-income countries that is creating obesogenic food environments and increasing the prevalence of chronic disease. The evidence linking nutrition transition processes to trade is not conclusive, but highly suggestive. The growth of transnational supermarkets has also led to changes in food availability, accessibility, price and, through marketing, desirability, shifting demand for home-produced foods or foods purchased in traditional markets to increased dependence on store-bought foods, especially processed foods. The dietary impacts of this shift, however, have not yet been subject to rigorous investigation.

    Policy implication: Many LMICs are now suffering multiple burdens of disease as chronic (often diet-related) illness co-exists with infectious epidemics. Global regulation of food trade is increasingly considered important for two reasons: improving domestic food security and decreasing the health problems of over/under malnutrition. The challenge will be to gain sufficient national governments' support to commence negotiations of a framework convention related to food trade, using the FCTC as a potential model.

    Research challenge: The 'suggestive evidence' of globalisation's role in creating obesogenic food environments needs strengthening.

13. Global financial flows affect SDH, notably through portfolio investments, Foreign Direct Investments, capital flight and remittances. However, the poorest countries of the world, notably in sub-Saharan Africa (SSA), receive only small portions of these global financial flows. Many least developed and low income countries rely heavily on official development assistance (ODA) to finance their health and SDH investments. This is likely to continue for decades, given even the most optimistic projections of economic and population growth.

14. There is now a strong body of evidence supporting aid effectiveness. Aid may lift as many as 30 million people out of absolute poverty each year. This evidence of aid effectiveness has been accompanied by a shift from off-budget programme or project-based aid to on-budget support. This allows recipient countries greater flexibility in responding to their self-selected development priorities, rather than those of donors. General budget support, however, is still fairly rare; recipient countries continue to be chosen more on the basis of donor countries' geopolitical, trade and security interests than on humanitarian concern or actual need, or according to the degree they demonstrate "good performance" as defined by the donors. Much aid remains inefficiently tied to the purchase of goods or services provided by the donor.

    Policy implication: Aid coordination and alignment could best be improved through globally pooled funds that are multilaterally managed and transparently governed, with eligibility and allocation determined according to agreed needs and development objectives, and with multi-year stability of donor inputs and recipient receipts. At a minimum are requirements for increased and sustained levels of untied aid, with increasing amounts disbursed through direct budget support. Finance ministers in recipient countries may be justifiably concerned with large health sector infusions that have guarantees of three years or less. Given increased arguments that the Millennium Development Goals (MDGs) should be used as a guide to aid flows and debt cancellation, the MDGs should be revised to incorporate equity measures and to ensure that greater attention is given to SDH.

    In an increasingly globalised economy, resources for important public infrastructures supporting health equity and actions on SDH also need to be considered as global obligations, rather than intermittent charity or creation of 'aid dependency.' This requires reform of the aid architecture away from donor-driven interests towards health and development goals consistent with multilateral agreements (such as the MDGs, assuming incorporation of equity stratifiers) and developing country contexts/priorities.

    Research challenge: Debate on aid effectiveness persists. This perforce requires ongoing study of aid reforms relative to effectiveness in increasing health equity and attaining agreed upon development goals related to SDH. Concerns about macroeconomic stability, backed by IMF macroeconomic and monetary policy conditions, have meant that much of the aid to indebted LDCs and LICs has gone to domestic debt payments and international currency reserves rather than to health and development investments. This underscores

the importance of continuous monitoring of the flows of development financing and conditionalities associated with it to ensure that the latter does not impede the intended purposes of the former.

15. Foreign debt represents a significant cross-border financial flow affecting health and livelihoods in both low- and middle-income countries. The debt crises that have been a feature of the international financial and political landscape over the last 25+ years are themselves a reflection of the world's increasing interconnectedness. Further, foreign debt and associated policy reforms have been used by developed nations to lever more globalisation, in the form of trade and financial liberalisation. Some of the hardest-hit countries, known as the Heavily Indebted Poor Countries (HIPCs), have seen a massive increase in debt over the past four decades, whilst their per capita incomes have stagnated. The 1996 HIPC Initiative of debt forgiveness has led to only modest decreases in debt servicing costs in most eligible countries, and the list of eligible countries excludes many in which the bulk of the world's poor live.

16. The Multilateral Debt Relief Initiative (MDRI) of 2005 now allows 100 percent cancellation of the debts owed by HIPC nations to four multilateral institutions (the IMF, the Inter-American Development Bank, the African Development Fund and the International Development Association (IDA), the concessional lending arm of the World Bank. While debt relief may be delivering modest resources which benefit the social determinants of health, principally through increased education spending, it is nowhere near the levels required.

    Policy implication: Changes in how debt sustainability is calculated are required, either estimating the amount of public revenue required to meet the MDGs before determining affordable debt-servicing, or working backwards from a feasible net revenue approach based on public investments required to support an average life expectancy at birth of 70 years (i.e., the 'ethical poverty line'). A multilateral consensus against collecting odious debts should be promoted.

17. Poverty Reduction Strategy Papers (PRSPs) required for debt relief and, encompassing a larger group of countries, aid disbursements, demonstrate some improvements in health and SDH policies but are limited by explicit or implicit macroeconomic conditionalities. They have also caused delays in debt cancellation flows.

    Policy implication: The PRSP process could be made more helpful in terms of supporting SDH by incorporating employment targets with a gender dimension, an emphasis on incomes that at the very least will lift households out of absolute poverty, and compliance with core international labour standards.

19. The PRSP process also instantiates a more general problem: the extent to which access to external financing, including debt relief and also private sector investment, is contingent on meeting performance criteria specified by the IMF. The debate about the extent to which IMF programmes constrain countries'

ability to utilise increases in development assistance for meeting basic needs (e.g. by way of wage bill ceilings) shows the need for policy attention to maintaining and expanding national policy space, and also to how health equity and SDH considerations figure in today's institutions of global governance.

Policy implication: Available evidence strongly suggests that wage bill ceilings as part of IMF deficit- and inflation-reduction targets are unnecessarily restrictive and prevent scale-up of many essential health interventions and/or government investments in SDH in LDCs and LICs.

Research challenge: Evaluation studies are needed of health equity and macroeconomic impacts of more expansive fiscal and monetary policies in LDCs and LICs.

20. The Commission on Social Determinants of Health (CSDH) has embraced the international human rights framework as the appropriate conceptual and legal structure within which to advance towards health equity through action on SDH. Yet globalisation is weakening the entitlements of many people to the progressive realisation of their right to health. This is particularly so with respect to access to health care, food security and water/sanitation.

21. Key international institutions have contributed to health care resource scarcities, in particular as they affect the poorest and most vulnerable, by promoting a market-oriented concept of health sector reform that strongly favours private provision and financing (commercialization). From the mid-1980s until quite recently, the World Bank in particular actively promoted a paradigm of health sector reform that viewed private provision of health care and the purchase of health care or health insurance on the open market as the normative baseline. Such a focus on a narrow conception of technical and economic efficiency has also privileged narrowly-defined cost effective medical interventions. This focus, combined with new sources of funding through Global Public-Private Partnerships directed at vertical, disease specific interventions, has mostly resulted in increased inequity of health care access and increasingly fragmented and ineffective health systems.

Policy implication: On the principle of 'first, do no harm', no further reforms based on neoliberal health sector reform should be implemented, at least until and unless evidence of their appropriateness, effectiveness and affordability in low- and middle-income countries has been established. On the other hand, there is evidence that publicly funded and universal systems which integrate strong primary health care with public health interventions are associated with better health outcomes and fewer inequities. LMICs may need to start with social insurance systems as they develop the tax capacities to fund more universal systems with broader risk-pooling and cross-subsidisation benefits.

Research challenge: Many LMICs continue to have a mix of private, social insurance and public health systems. Studies are needed of how well this mix can serve health equity, how it can best be managed, and the extent to which

private and social insurance systems integrate supporting actions on SDH; as are policy lessons for how well LMICs are able to move towards universal systems. As well, with renewed multilateral interest in primary health care and evidence of the lack of reach and sustainability of many vertical global health initiatives, evaluative research is also needed on how such global health initiatives are able to strengthen national health systems, and to take into account the role of SDH in the disease causes/consequences of their focused interests.

22. Globalisation contributes in various ways to the migration of health professionals. This migration is asymmetrical – from poor countries to rich ones – with the poorest countries unable to attract replacement workers. The result is diminished health care access and services. The absence of an adequate density of health workers, in turn, correlates with increased mortality (i.e. IMR, U5MR and maternal). A notable trend within developing countries is the internal migration of health personnel from public to private health care systems and from rural or under-served areas to urban communities. This trend is partly a result of the pull from rich countries, with positions in urban communities seen as a necessary stepping stone to recruitment abroad; and of increased trade in private health services leading to a boom in so-called 'medical tourism.'

    Policy implication: Policy measures to mitigate the loss of health professionals include programmes to promote return migration (minimal impact/high cost), restricted emigration (minimal impact) or immigration (moderate impact but unpopular), bi- or multilateral agreements (somewhat successful but limited in scope), improved domestic HHR planning and self-sufficiency (widely endorsed but not followed and against the grain of growing global labour market integration), greater use of auxiliary health workers in LMICs who would be less likely to migrate for 'pull' reasons, restitution/compensation (potentially most equitable but not popular with countries accepting HHR émigrés).

    Research challenge: Research on the actual or potential effect of all policy measures remains important. At base, more accurate estimates of the flow/circulation of HHR are needed, as are estimates of the net health costs/benefits to source and receiving countries. The combination of 'push' and 'pull' forces in HHR migration is a symptom of the increasing wealth inequities between source and receiving countries, raising questions of how the flow of financial and human capital from poor to rich countries can be offset by rebalancing economic relations between rich and poor countries. Some options (e.g. bilateral tax agreements between source and receiving countries, taxes on medical tourism) are amenable to feasibility study. While several LMICs are increasing their production of health workers specifically for export or for medical tourism, the impact of this on health equity within their own countries remains an important research and policy issue.

23. A key concern with international trade treaties is that trade commitments may lock-in policy choices that are detrimental to health outcomes. This is

particularly the case for trade (including investment) in health services, given the sector's susceptibility to market failure.

Policy implication: While governments may still want to experiment with commercialisation in some components of their health systems, making these policy experiments part of binding trade treaties will strongly limit their ability to undo these reforms if they wish to do so in the future. Unless, and until, governments have experience regulating private investment and provision in health services in ways that enhance health equity, and that these are consistent with their obligations related to the right to health, they should avoid making any commitments in binding trade treaties. At a multilateral level, cancelling existing trade treaty commitments and removing health services from the scope of trade treaties remains an option, albeit one with low political feasibility given the interests of private health insurance and other service companies in the EU, USA and some middle-income countries.

24. The key challenges for water/sanitation are ensuring sustainability in supply and affordability in access. Globalisation has diffused new approaches to the former, emphasising innovative technologies easily adapted to poor and rural settings (e.g. closed loop sanitation systems and waterless urine diversion toilet systems) and greater attention to management scale at the water-catchment level. With respect to the latter, globalisation has seen increased involvement of water transnational corporations in the management or supply of water in many low- and middle-income countries. This has often led to inequities in access, public dissent, the withdrawal of private investment and, so recently the results cannot yet be assessed, experimentation with 'public-public' partnerships involving public agencies cooperating in worker- and community-controlled water systems, as in Bolivia and Venezuela.

    Policy implication: For those already on a grid supply, water pricing should be reformed with much greater cross-subsidisation, a guaranteed free 'lifeline' supply and tariff-structuring that provides incentives to conserve.

    Research challenge: Water scarcity is increasing in many parts of the world. Water access is a basic determinant of health as well as many of the economic activities that may reduce poverty. A key question is how the economics of water accessibility and use can be managed for purposes of health equity and sustainability.

25. Trade reforms in agriculture can affect health equity through its impact on food security. Trade liberalisation can also, but not always, negatively affect nutritional food security at the household level. Where improvements have occurred, most were attributed to female-controlled incomes within the household.

    Policy implication: For low-income countries whose economies are still heavily dependent on agriculture, raising agricultural productivity and creating non-agricultural employment should precede trade reforms such as the

reduction of tariffs on crops grown by low-income households. Global market instabilities in food supply and price also require mitigating national policies, notably in low-income countries, ranging from targeted input subsidies and supports to improved rural infrastructure, to compensatory measures for low-income groups.

Research challenge: Evaluative studies of agricultural policy reforms and compensatory measures in terms of health equity impacts, and of options for broader rural development, including diversification and off-farm income generation.

26. Expanding Intellectual Property Rights (IPRs), notably TRIPS and 'TRIPS-plus' agreements, jeopardise equitable access to patented medicines. While IPRs do stimulate new research and development (R&D) by pharmaceutical companies, such R&D goes primarily to treatments for problems in high-income countries that can afford to pay for them. Consumers in developing countries thus contribute to the R&D budgets of pharmaceutical companies but are unlikely to benefit from future innovations to the same extent, if at all, as consumers in developed countries. Policy flexibilities for compulsory licensing were clarified in the Doha Ministerial Declaration on TRIPS and Public Health. Subsequent agreements were reached to permit parallel importing of generic drugs but with excessively burdensome conditions. TRIPS-plus agreements are removing even these flexibilities.

    Policy implication: To minimise health inequities due to stronger and expanding IPR regimes, developing country governments should actively participate in the Intergovernmental Working Group on Intellectual Property Rights established by the World Health Assembly, ensure that their national legislation allows full use of the flexibilities provided for by TRIPS, explore the use of compulsory licenses of patented essential medicines whenever the price can be significantly reduced through competition (local production or importation) and avoid concessions in bilateral or free trade agreements that increase the level of IPRs protection.

    Research challenge: WHO, as a matter of priority, should evaluate mechanisms other than the patent system, such as contests, public-interest research funding and advance purchase agreements, to encourage the development of drugs for diseases that disproportionately affect developing countries. Consideration should also be given to whether stronger incentives for commercial product development under current intellectual property regimes have potential negative effects for such approaches.

27. Under the current system, SDH are not well served by global governance mechanisms, either within the field of health or more generally. This is reinforced by the fact that few multilateral institutions with mandates affecting SDH abide by criteria for good governance.

Policy implication: While more detailed studies of global governance for SDH are required, preliminary findings point to a need to: strengthen governance through core (regular budget) funding of WHO and other UN agencies with SDH mandates; establish the United Nation's Economic and Social Council, with WHO, as lead institutions for coordination of multilateral actions on SDH; democratise international institutions by increasing the representation of developing countries, increasing and equalising their accountability to members, improving their transparency and increasing their openness to civil society organisations; create a permanent and sufficiently resourced position of UN Special Rapporteur on the Right to Health. A comprehensive review of the overall and out-dated system of global governance established after the Second World War should be initiated urgently with a view to establishing a system conducive to health equity in the context of the conditions, needs and generally accepted principles of governance in the 21st century.

Research Challenge: There is a need for research on governance mechanisms at the global level which would provide an effective basis for collective decision-making in the collective long-term interest of the world population, on an equal basis, with appropriate standards of transparency and accountability. Research is also needed on reform processes which could overcome the inertia associated with the current concentration of power in the global system of governance.

28. A global governance policy agenda that responds to globalisation's present asymmetries can usefully be structured around the "three R's" of redistribution, regulation and rights (in the words of a team from the Finnish social policy research unit STAKES), and will require coordinated action on an international scale by national governments and multilateral institutions.

Policy implication: The most productive areas for policy innovation include: international or global taxation (e.g. of air travel and financial transactions); regulating the use of offshore financial centres to avoid existing national tax regimes; and taking full account of the implications for the right to health in decisions on trade policy commitments. More generally, the international human rights framework presents opportunities for limiting commodification and the spread of the global marketplace in ways that undermine health equity.

Research challenges: There is a need for investigation of the potential mechanisms, revenues and broader economic effects of alternative forms of global taxation and of regulation of offshore financial centres; and health assessments of proposals in international trade agreements on an ongoing basis.