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ON HEALTH SYSTEMS RESEARCH
Science to accelerate universal health coverage

The international political economy of global universal health coverage

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KEY MESSAGES

If universal health coverage can be described as a limited set of options to finance essential health goods (“appropriate promotive, preventive, curative and rehabilitative health care”) to make them affordable to all, little research has been done about how international health financing can best be linked with national health financing to attain this goal. Universal health coverage is—often implicitly—viewed as a strategy to make international health financing redundant. This is at odds with cost estimates used by the WHO for essential health goods: evidence suggests that domestic financing of US\$40 per person per year is unfeasible for countries with an average Gross Domestic Product of \$995 or less (the World Bank’s definition of low-income countries). We therefore distinguish between *global* universal health coverage—which assumes international health financing integrated with national health financing for essential health goods—and *national* universal health coverage—which assumes that international health financing is temporary. We focus on *global* universal health coverage because we believe it could be feasible before 2020, at least mathematically, while *national* universal health coverage appears unrealistic for low-income countries in the short to medium term.

Global universal health coverage would entail national universal health coverage with an additional integrated international dimension (co-financing the national tax-based or social health insurance based financing). It would require international health financing to use the chosen national financing mechanisms as entry points, and to be sufficient, additional and reliable in the long run.

Political economy aims to answer the question why policy-makers adopt the policies they adopt. Mainstream literature on international political economy assumes that countries are mostly self-interested. Why would self-interested countries become involved in concerted global health action, and perhaps in global universal health coverage? Several arguments have been raised; we try to summarize them and assess their validity. We conclude that the most convincing arguments (from a narrow self-interest angle) are:

- Concerted global health action can help contain communicable diseases;
- Concerted global health action can strengthen national social cohesion;
- Concerted global health action promotes economic growth;
- Concerted global health action can help reduce desired fertility rates and in the long term contribute to slowing climate change.

Taken together, rather than separately, they appear to build a solid case for global universal health coverage, but they require additional research (a lot of which goes beyond conventional health systems research).

If, as we argue, the case for global universal coverage is strong, why might it not be pursued? There may be a problem of ‘free riders’ (countries hoping that other countries will pay for a global public good), but the main obstacle would be that global universal health coverage reduces country autonomy and embraces a paradigm of managing mutual dependence. Even if mutual dependence in health is a reality, countries nonetheless try to preserve their autonomy: richer countries require assurances regarding how the assistance they provide will be used (in a manner that serves their interests too); poorer countries want to have the freedom to address their own health priorities. Recent paradigm shifts in the practice of international health financing can be seen as attempts to manage mutual dependence in health while trying to preserve country autonomy. Over the past decades, these attempts to better manage mutual dependence in health have led to increasingly sophisticated governance mechanisms. We suggest that a combination of the best elements of these mechanisms could help progress the world towards global universal health coverage.

EXECUTIVE SUMMARY

1. International financing for universal health coverage in developing countries: an unexplored field of research

If universal health coverage can be described as a limited set of options to finance essential health goods (“appropriate promotive, preventive, curative and rehabilitative health care”) to make them affordable to all, little research has been done about how international health financing can best be linked with national health financing to attain this goal. Universal health coverage is—often implicitly—viewed as a strategy to make international health financing redundant. For example, the consortium on social health protection in developing countries of the *Deutsche Gesellschaft für Technische Zusammenarbeit* (GTZ), the International Labour Office (ILO) and the World Health Organization (WHO), mentions that “[i]n the long term, all schemes should become as financially independent of external funding as possible”. If international health assistance is intended to be temporary then its integration with *national* universal health coverage efforts would imply the failure of both: international health financing would become open-ended and universal health coverage would not achieve its implicit goal of ending dependence on external funding.

While understandable, this reluctance to consider international health financing as a sustained source of financing for universal health coverage, it is at odds with cost estimates used by the WHO for essential health goods: evidence suggests that US\$40 per person per year is unfeasible for countries with an average Gross Domestic Product of \$995 or less (the World Bank’s definition of low-income countries), no matter which combination of taxes and insurance fees one may try. We therefore distinguish between *global* universal health coverage—which assumes international health financing integrated with national health financing for essential health goods—and *national* universal health coverage—which assumes that international health financing is a temporary aid to national efforts. This paper focuses on *global* universal health coverage because we believe it could be feasible before 2020, at least mathematically, while *national* universal health coverage seems unrealistic for low-income countries in the short to medium term.

2. Global universal health coverage: what is required?

Global universal health coverage would entail all elements of national universal health coverage, but with an integrated international dimension which co-finances the national tax-based or social health insurance based financing. It would require international health financing to use the national financing mechanisms as entry points, and to be sufficient, additional and reliable in the long run. In recent years, a few conceptual approaches to global health that could lead to global universal health coverage have been floated. However, additional research seems to be needed to clarify a few essential elements:

- If WHO defines universal health coverage as a financing mechanism based on taxes, social health insurance or a mixture of both, sufficient to finance “appropriate promotive, preventive, curative and rehabilitative health care when [people] need it and at an affordable cost”, the question of how we define ‘appropriate’ remains unanswered;
- If the international financing dimension is open-ended but nonetheless complementary, it raises the following questions: what amount can countries reasonably finance themselves; how much assistance would be needed and how long would the assistance be needed?

3. Why would countries undertake concerted global health action and perhaps global universal health coverage?

Political economy aims to answer the question why policy-makers adopt the policies they adopt. Mainstream literature on international political economy assumes that countries are mostly self-interested. Why would self-interested countries become involved in concerted global health action, and perhaps in global universal health coverage? From four key documents written to highlight how concerted global health action also benefits those countries providing the required assistance, we extracted ten arguments and assessed their relative merits.

Concerted global health action helps reduce the risk of communicable diseases spreading. This argument seems undisputed. The controversy that surrounds it focuses on the risk that the argument may lead to the wrong kind of global concerted health action.

Concerted global health action can improve social cohesion and reduce the risk of political instability and armed conflict. This argument needs to be unpacked: armed conflicts provide sanctuaries for terrorist groups; stronger health services help reduce the risk of armed conflicts. The evidence for this argument appears weak, but that could be due to insufficiently refined methodologies; in recent years new research approaches have been developed and they seem to confirm the argument.

Concerted global health action creates diplomatic goodwill. While this argument seems self-evident, we found it too vague—in terms of the benefits for countries providing the assistance—to assess.

Concerted global health action can ease undesired pressure for migration. We found no evidence for this argument, except indirectly: if concerted global health action contributes to economic growth, economic growth reduces intention to migrate.

Concerted global health action contributes to economic growth. A lot of research has been produced to verify this argument; the evidence is mixed but overall affirmative.

Concerted global health action creates a market for health goods and services. This argument has not been deeply researched, perhaps because it would lead to the wrong kind of concerted global health action. There is evidence that a substantial share of international health financing is used for the purchase of commodities and services from richer countries; however, if the intention were to stimulate the domestic economy, richer countries would rather invest in domestic stimulus efforts.

Concerted global health action can have a positive impact on the environment. The argument that concerted global health action—through its impact on infant mortality and thus on desired fertility rates—can in the long run help to protect the environment seems solid. It could be a very convincing argument, given the cost estimates for other ways of reducing greenhouse-gas emissions.

Concerted global health action is needed to realize the human right to health. It is not easy to understand this argument as one that affirms the interests of countries providing the assistance. Conceptually, one could argue that present efforts to promote some human rights—the civil and political human rights—would become a lot more credible if they were accompanied by serious efforts to also realize economic, social and cultural human rights, including the right to health.

Concerted global health action is needed for human security. The human security concept intrinsically links security threats of all kinds and argues that human security can no longer be guaranteed by countries acting individually. From its inception it thus appeals to countries' self-interests and more generous motives. Rather than as a stand-alone argument, the human security concept provides an analytical framework that allows for the combining of different arguments.

Concerted global health action is needed because health is a global public good. The global public goods concept, like the human security concept, emphasizes interconnectedness beyond borders: some public goods can best be obtained through concerted global action, and health is one of them. While there is a consensus that the containment of communicable diseases is a global public good, the question as to whether other elements of global health can also be considered as global public goods remains controversial. Like the human security concept, the global public goods concept provides an analytical framework that allows for the combining of different arguments. It also entails a warning about ‘free rider’ behavior: some countries may try to benefit from health as a global public good, while letting other countries pay for it.

4. How? Looking for a balance between managing mutual dependence and preserving country autonomy

The Declaration of Alma Ata contains a tension: on the one hand it affirms health as a “fundamental human right” and a “world-wide social goal”, and that “existing gross inequality in the health status of the people” is a “common concern to all countries”; on the other hand it promotes health care at a “cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.” Thus to reconcile both, international assistance should aim for the economic growth of poorer countries, so they would be able to provide better health care while preserving country autonomy. This interpretation may have paved the way for selective primary health care as a temporary solution: encouraging only the health interventions considered as most cost-effective, while waiting for the poorest countries to become less poor.

All subsequent major paradigm shifts in international health financing can be seen as increasingly sophisticated attempts to find a balance between managing mutual dependence and preserving the autonomy of the countries providing the assistance and of the countries receiving the assistance:

- Project financing allowed donor countries to maintain direct control over the use of the assistance they provided, while recipient countries were—in principle, at least—allowed to refuse projects; project funding also maintained the illusion that national financing would eventually replace international assistance;
- Under Sector-Wide Approaches, donor countries abandoned direct control but became involved in the management of the entire health sector of recipient countries;
- Public-Private Partnerships for health allowed donor countries to earmark the financing they provide to specific purposes, yet these Partnerships created governance bodies in which recipient countries—and representatives of their civil society—have a stronger voice;
- The World Bank provides a channel for international health financing that is controlled by donor countries (because of the ‘one dollar, one vote’ principle of World Bank governance), but recipient countries can—again, in principle—refuse World Bank financing; it should be noted that the ‘replenishment’ mechanism of the World Bank has been exceptionally stable for several decades.

A combination of the most promising elements of all these attempts to manage mutual dependence, while preserving country autonomy, could be used to help achieve global universal health coverage.

GENERAL INTRODUCTION

Framing the subject and methodology

Framing the subject

The original title of this background paper was “Review paper on the political economy of transnational dynamics on universal health coverage”. We were asked to focus on the role of transnational or international dynamics on universal health coverage, as the national dynamics are the subject of a different background paper. In particular, we were asked to:

1. Synthesize state-of-the-art knowledge on accelerating progress towards universal health coverage generated through Health Systems Research (HSR);
2. Review state-of-the-art methods used in HSR;
3. Explore how research in HSR can be strengthened—i.e. methods, human resources, the knowledge generated, and the evidence-to-policy linkages—can be strengthened;
4. Suggest where resources should be directed.

We found very little research on how transnational or international dynamics affect progress towards universal health coverage. In contrast, extensive research has been done on how international dynamics affect the health of people (in particular about international health financing), but not systematically on how these dynamics affect progress towards universal health coverage. Likewise, a substantial body of research has been produced on universal health coverage—what it means, why it should be promoted, how it can be promoted—but most of this research is focused on national dynamics and national financing in particular.

If the key to universal health coverage is tax-based financing, social health insurance or a mix of both,¹ there are examples of international financing for universal health coverage. A well-known example is the support the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) gives to Rwanda’s mutual health insurance scheme.² While Samb and colleagues observe that Global Health Initiatives (GHIs) like the Global Fund have, in contrast to the Rwanda example, not invested systematically in the development or extension of prepayment health financing mechanisms,³ something similar can be said about health systems research: the potential of complementing tax-based financing or social health insurance with international health financing has not been systematically investigated. Kalk and colleagues suggest that the same Global Fund grant to Rwanda might “become a strong argument for broadening the Fund’s mandate and for subsequently transforming it into a ‘Global Fund for International Health Promotion’”,⁴ but we did not find research papers that explored this suggestion further. Likewise, health sector budget support—in the form of Sector-Wide Approaches (SWAs) or otherwise—could be seen as international financing for universal health coverage: health sector budget support complementing tax-based financing, pooled within a single budget. However, we found no research investigating the potential of health sector budget support complementing tax-based financing to achieve universal health coverage. For example, Schieber and colleagues mention SWAs as an increasingly important health financing tool for low-income countries, and universal health coverage as a health financing method for middle-income countries, but they do not link both.⁵ As it seems, *never the twain shall meet...*

This is the first and probably foremost observation of this paper: research about international health financing and research about universal health coverage seem to be two quite distinct fields of research, with the first focusing on international dynamics and the latter on national dynamics.

We could have focused on this point, and completed our review with this observation: there is no systematic research about international health financing for universal health coverage, there is nothing to be written about research methods, there is only a vacuum waiting to be filled. Instead, we chose to use this observation as a starting point. Based on reactions to our own papers, in which we proposed a ‘World Social Health Insurance’,⁶⁷ or a ‘Global Health Fund’,⁸ we suspect that the vacuum is neither a coincidence, nor an accidental omission. We posit that universal health coverage is, often implicitly, proposed as a means of ending the dependence of poorer countries on international health financing and thus achieving self-sufficiency in health financing. For example, the consortium on social health protection in developing countries of the *Deutsche Gesellschaft für Technische Zusammenarbeit* (GTZ), the International Labour Office (ILO) and the World Health Organization (WHO), embraced the ‘Berlin Recommendations for Action’, which mention: “In the long term, all schemes should become as financially independent of external funding as possible”.⁹ International health financing is thus viewed as a temporary phenomenon—a temporary problem, perhaps—waiting for and encouraging national health financing capacity to ramp up and take over. Based on this understanding, combining international health financing with national universal health coverage efforts, or considering international health financing as an essential element of universal health coverage, would institutionalize the failure of both: universal health coverage would not mean independence from external funding, and international health financing would become perennial—or at least open-ended.

Whether it is desirable to aim for autonomous self-sufficient countries, or more desirable to acknowledge mutual dependence between countries—and to manage this mutual dependence, in health and other fields—is a question that goes far beyond health systems research. It is a philosophical question about the relations between people living within the borders of the same state and about relations between people living in different states (or about relations between states). Without exploring this question in depth, we do assume that the aim of realizing universal health coverage within a reasonable time frame is not compatible with the aim of autonomous self-sufficient states:

- Adopting the assumptions of Carrin and colleagues, we assume—at least temporarily—that the basic set of health goods and services that qualify as universal health coverage costs at least US\$40 per person per year;¹⁰
- Basing our assumptions on the findings of Schieber and colleagues, we assume that taxation efforts in developing countries can realistically aim for government revenue of 20% of their Gross Domestic Product (GDP);¹¹ and referring to the Abuja Declaration, we assume that developing countries can allocate 15% of government revenue to health.¹² The combination of the latter two assumptions leads to the assumption that developing countries can at best allocate the equivalent of 3% of GDP to tax-based financing of universal health coverage, which is also the target used by Global Health Watch;¹³
- Finally, we assume that mandatory social health insurance fees, to guarantee “solidarity between the healthy and the sick, and between population groups in all income classes”,¹⁰ are on a par with income taxes, in the sense that any increase in mandatory social health insurance fees leads to a decrease in potential income taxes, and vice versa.

Using these assumptions, we conclude that only countries with an average GDP per person per year of \$1,333 or more might have the financial potential, domestically, to provide country-wide health coverage. According to the ‘World Economic Outlook’ data of the International Monetary Fund (IMF), there are 59 countries with an average GDP per person per year of less than US\$1,333, and they have a total population of 2.5 billion people. There are 37 countries with an average GDP per person per year of less than \$666, and they have a total population of 760 million people; these countries would have to at least double their GDP before they can provide universal health coverage at \$40 per person per year (Annex 1). Thus, even without answering the question as to whether it is desirable to acknowledge and manage the inter-dependence of

countries, we assume that universal health coverage at a cost of \$40 per person per year without international health financing before the year 2020 is not a realistic perspective.

Universal health coverage coupled with an open-ended international financing dimension—or ‘global universal health coverage’ as we shall term it—is thus not a matter of choice: it is the only way to realize universal health coverage before the year 2020. Universal health coverage without an open-ended international financing dimension—or ‘national universal health coverage’—may represent the conventional understanding of universal health coverage, but it is not a realistic endeavour (for at least 37 countries, with 760 million people). The difference between these approaches is that global universal health coverage would aim for international health financing that is in all aspects complementary to national efforts towards universal health coverage:

- Using the entry points for international health financing that reinforce the country’s plan for achieving universal health coverage (tax-based, social health insurance based, or a mixture of both), rather than financing disease-specific programs through a wide variety of initiatives;
- Sufficient to complement national efforts, without aiming for self-reliance, but in a manner that ensures additional funds, and which requires firm commitments from both sides;
- As reliable as national health financing sources.

Following our initial research we decided to focus on global universal health coverage, knowing our approach would displease all those who prefer to keep international health financing and universal health coverage separate.

While health systems research cannot answer the general question as to whether it is desirable to aim for autonomous self-sufficient countries or more desirable to acknowledge and manage the increasing inter-dependence of countries, it can provide answers to some of the more specific questions. If global universal health coverage is a new approach, that does not mean that all the questions it raises are new. For example, the question of why richer countries would co-finance universal health coverage in poorer countries is not fundamentally different from the question of why richer countries would participate in concerted global health action. Disaggregating the more specific questions allows us to examine the extent to which they have been researched, or not.

Methodology

The first section of this paper is about the ‘what?’ question. It aims to set the stage for global universal health coverage. What would it entail? What would it aim for? These are relatively new questions, and as mentioned above, they are at odds with the conventional understanding of (national) universal health coverage. We presume that we have been invited to write this paper because of our previous conceptual work on these questions, and therefore we did not undertake a systematic review of the literature on this question (we relied on our knowledge). One could term it the definitional section of this paper, and, given the lack of a widely accepted definition of global universal health coverage, we took the liberty of defining it. That does not mean we started from scratch. Our definition is based on assumptions that have been researched and where appropriate, we highlight the strengths and weaknesses of existing research.

The second section of this paper is about the ‘why?’ question. Why would some (richer) countries participate in global universal health coverage, assisting other (poorer) countries? This question is new too, but not fundamentally different from the older question about why richer countries participate in concerted global health action. The second section is the central piece of the paper and it reflects the specific research we did for this paper. Political economy is

about “understanding choices about policy and the factors that influence the adoption, implementation, and consolidation of policy reform initiatives”,¹⁴ and this section aims to capture why countries would participate in global universal health coverage. As the mainstream literature about the international political economy seems to adopt, as Martin phrased it, “fairly pessimistic assumptions about state interests and intentions”,¹⁵ we adopted these assumptions too—at least for this background paper—even if such an approach conflicts with our personal opinion that health is a human right, to be realized whether or not it serves the interests of states contributing to its realization. We frame our discussion around four key documents that attempt to provide an exhaustive list of arguments for richer countries to co-finance efforts to improve health in poorer countries, in the self-interest of the richer countries (altruistic motives not included). From these documents, we distilled a list of 10 arguments, and for each of those we assessed the strength of the supporting evidence and where necessary highlighted areas requiring additional research. As some of these arguments are beyond the scope of health systems research or even beyond the scope of public health research, we used Google Scholar instead of medical search engines to research each of the arguments.

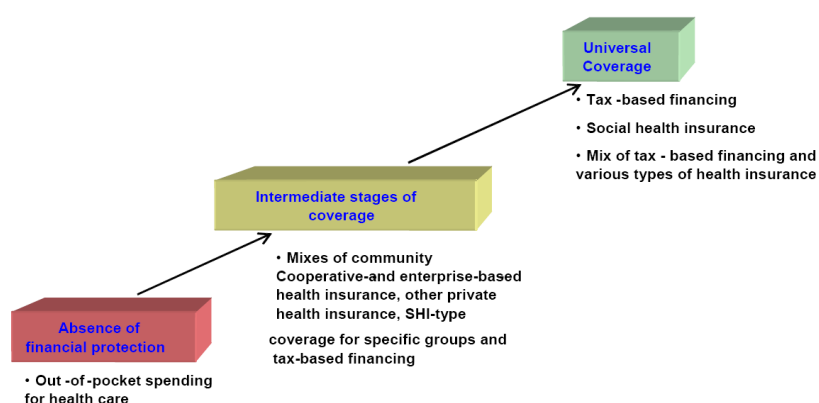
The third section of this paper is about the ‘how?’ question, which is essentially the discussion section. How can global universal health coverage be achieved, if states are presumed to be self-interested? Are recent trends in international health financing moving towards or away from global universal health coverage? As global universal health coverage is a new concept, one cannot infer intent from the trends in international health financing. However, the crucial challenge of global universal health coverage, as we will explain, seems to be a challenge of managing mutual dependence or inter-dependence between countries, while trying to preserve country autonomy. We will analyze recent trends in international health financing from this angle, to conclude that several attempts have been made to manage mutual dependence, and that taking the most promising elements of these attempts could pave the way for global universal health coverage.

Section I. What would global universal health coverage entail?

I.1. Introduction

Global universal health coverage, as we define it, is national universal health coverage with an integrated international financing dimension, the international dimension being in all aspects complementary to national efforts. We refer to Carrin and colleagues for a definition and description of national universal health coverage.¹ As illustrated by figure 1 below, universal health coverage is achieved when tax-based financing, social health insurance or a mixture of both finance “appropriate promotive, preventive, curative and rehabilitative health care when [people] need it and at an affordable cost”. These financing mechanisms are viewed as appropriate for ensuring “equity in financing, i.e. that people contribute on the basis of ability to pay rather than according to whether they fall ill”.

Figure 1. “The transition to universal coverage”



Copied from Carrin et al., 2005

This provides two entry points for the international financing dimension: either the health sector budget (where international financing complements tax-based financing), or social health insurance institutions, or a mixture of both.

Global universal health coverage would require more than simply shifting current international health financing streams to those entry points. International health financing would have to be:

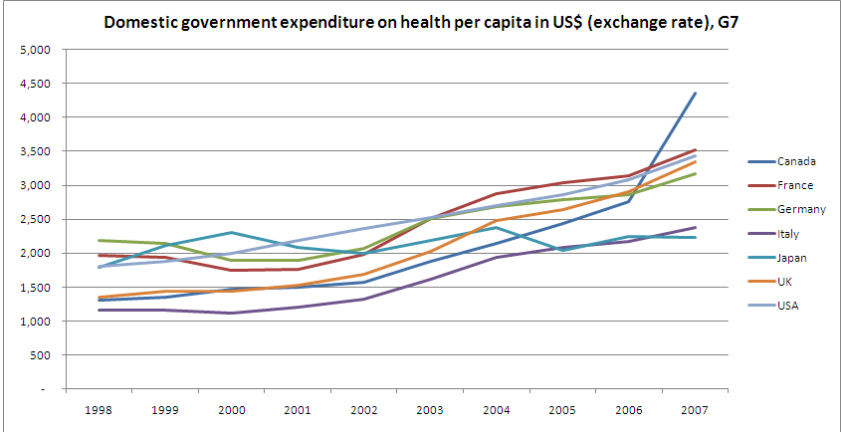
- Sufficient;
- Additional to national efforts, and;
- Equally reliable as domestic efforts.

What would be a sufficient level of international health financing? We have used the \$40 per person per year figure provided by Carrin and colleagues,¹⁰ in combination with the target for national health financing efforts used for example by Global Health Watch: “All countries to set a target to raise at least 20% of their GDP as tax revenue, and to allocate at least 15% of total government expenditure to health”.¹³ Combining these estimates with present levels of GDP (as we did in Annex 1) results in a total of about \$50 billion per year as the sufficient level of international health financing. However, both the \$40 figure—which is derived from the work of the Commission on Macroeconomics and Health, which assumed that presently available health care would continue and added a limited list of additional priority interventions¹⁶—and the 3% of GDP target are rough estimates; further research is required to refine them.

International health financing should be additional to national efforts for obvious reasons: if international health financing simply displaces national efforts, universal health coverage will not be achieved. ‘Additionality’, however, should not be taken for granted. Farag and colleagues estimate that in low-income countries “a one-dollar increase in donor funding is associated with a reduction in government funding of twenty-seven cents”; that in middle-income countries “a one-dollar increase in donor funding is associated with a reduction in government funding of sixty-three cents”.¹⁷ Lu and colleagues estimate that “[f]or all developing countries in the WHO dataset, the coefficient suggested that for every \$1 of [Development Assistance for Health] to government, the government reduced spending from its own sources by \$0.46”, and add that this is probably an underestimation.¹⁸ In commenting on Lu and colleagues’ paper, we suggested that the ‘crowding out’ phenomenon might be caused by the long-term unpredictability of international health financing: countries that are strongly reliant on international health financing will be reluctant to increase total government health expenditure (domestic and international) if they are uncertain about the reliability of the international component.¹⁹ Rather than refusing international health financing, they will reduce domestic health financing. Our hypothesis is based on research by Foster.²⁰ Nonetheless, this question requires additional research.

Finally, international health financing should be reliable in the long run, as reliable as national financing sources, to allow the recurrent expenditure needed for universal health coverage. Would this be at odds with the principle of democracy, according to which governments should not bind future governments to set allocations? As a matter of principle, this challenge is not fundamentally different from the challenge of planning domestic government health expenditure in richer countries. As figure 2 below illustrates, all members of the G7 (the seven largest economies) have managed to keep their domestic health financing stable and steadily increasing between 1998 and 2007. If the same level of reliability could be achieved for international health financing, it would contribute to the realization of global universal health coverage.

Figure 2: Domestic government expenditure on health



Source: WHO, National Health Accounts

Additional research

At this point, we would suggest that there is a need for additional research around trying to define or describe what “appropriate promotive, preventive, curative and rehabilitative health care” is or should be, adapted to national needs and priorities. The word “appropriate” contains a normative element: from which perspective should appropriateness be defined? From the perspective of the people who need it or from the perspective of all the people and states co-financing it? There are no simple answers to this question. We believe this kind of research should be truly multi-disciplinary, involving communities, health professionals, health economists, human rights lawyers and political scientists.

Likewise, it seems necessary to provide a more refined national health financing target than 3% of GDP: for some countries this may be excessive, for others rather modest. Here again, multi-disciplinary research will be needed, looking at recent trends but including a normative element.

The phenomenon of international health financing ‘crowding out’ national government health financing is not sufficiently understood, and crucial to an understanding of several related obstacles to global universal health coverage. The statistical approaches used so far by Farag and colleagues and Lu and colleagues mentioned above give us an idea of the magnitude of the problem, but do not explain why ‘crowding out’ happens. And here again, there is a normative element: are countries supposed to match increased international health financing with increased national efforts, or is it only reasonable that some of them shift national resources to other priorities, less favored by the international community? Using global universal health coverage as the starting point of additional research could help to improve our understanding of what is needed to ensure additionality.

1.2. Emerging concepts of global universal health coverage

In our earlier work, we have suggested that the current Global Fund could serve as a broad template on which to move towards a ‘World Social Health Insurance’,⁶⁷ or a ‘Global Health Fund’.⁸ The ‘essential health goods’—from here on, used as shorthand for “appropriate promotive, preventive, curative and rehabilitative health care when they need it and at an affordable cost”—to be co-financed internationally would be those that fall under the description of ‘core obligations’ arising from the human right to health,²¹ and are provisionally presumed to cost \$40 per person per year. Countries would have to demonstrate that they have exhausted their domestic financing capacity, provisionally estimated at the equivalent of 3% of GDP, and would have to submit a comprehensive plan to the Global Fund (with a broader mandate), to be reviewed by a technical panel. The burden would be shared among all countries that are donors to the International Development Association (IDA) of the World Bank. Thus countries would ‘graduate’ from being eligible for co-financing to non-eligible as soon as 3% of their GDP exceeds the financing required for the agreed essential health goods, and graduate to become co-financers in accordance with the rules of the IDA.

Deacon adopts a similar approach when he argues that “some of the technical allocation mechanisms used by the Global Fund might be built upon by a democratised and strengthened global social governance system within the context of the sustainable resources available from a global levy based on global taxation with funds flowing through normal government budgets”.²²

In recent months, several global health leaders have expressed their support for expanding the mandate of the Global Fund,^{23’24’25} including Minister Tedros Adhanom Ghebreyesus, the present chair of the board of the Global Fund.²⁶

Van Ginneken of the International Labor Office (ILO) argues that there is “need to start thinking about the global financing of basic social security”, and mentions the idea of a ‘Global Trust Fund’, financed by “voluntary social security contributions from wealthier countries”, financing programs “run by existing social administration institutions in the recipient countries”.²⁷

Milanovic of the World Bank proposes “creating a global body (Agency) that would be financed by a tax raised from the rich in rich countries (that is, a tax on goods or activities with very high income elasticity) and which would transfer these funds to poor *individuals* in poor countries”.²⁸

Faux proposes that “nations whose per capita income is above the median would contribute a certain share of their GDP to an international fund that would distribute it on a per capita basis to those below the median for education, health and other investments”, and that these funds “would constitute an entitlement, but would bring with it strict requirements for transparent reporting, and the protection of human and labor rights”.²⁹

This overview is not intended to be exhaustive; it only tries to illustrate that there are many diverse emerging ideas about redistribution of wealth beyond borders, which could be used to realize global universal health coverage could be realized.

Section II. Why would countries participate in global universal health coverage?

II.1. Introduction

This section is the central piece of the paper. Political economy is about “understanding choices about policy and the factors that influence the adoption, implementation, and consolidation of policy reform initiatives”,¹⁴ and this section tries to capture why countries would participate in global universal health coverage.

There are different ways to approach the question as to why countries would participate in global universal health coverage. Some of them are ‘prescriptive’: they prescribe what countries should do, from a moral, ethical or legal perspective. Some of them are ‘descriptive’: they describe what countries are likely to do, based on recent experience.

Two of us are human rights lawyers: we are inclined to use the prescriptive approach. But the task we were given—to review the political economy of transnational dynamics on universal health coverage—appears to require a descriptive approach. “Why *should* countries participate in global universal health coverage?” is not the correct question here; “Why *would* they?” is the right question.

Martin argues that “modern literature on international cooperation departed from earlier liberal, or “idealist”, conceptions of cooperation”, and “attempted to show that, even making fairly pessimistic assumptions about state interests and intentions, we could identify conditions under which states would find it beneficial and possible to cooperate with one another”. “Theories of international cooperation”, so argues Martin, “made a big leap forward by accepting the assumption that states are self-interested and have conflicts of interest with one another.”¹⁵ Embracing Martin’s theory of international cooperation, which draws on Keohane,³⁰ and Oye,³¹ our answers to why countries would participate in global universal health coverage are guided by the assumption that they are all motivated by self-interest.

II.2. Provisional inventory of arguments as to why countries would participate in global universal health coverage

Our provisional inventory is based on four key documents:

1. The 1997 report of the Board on International Health of the Institute of Medicine of the USA, ‘America’s Vital Interest In Global Health: Protecting Our People, Enhancing Our Economy, and Advancing Our International Interests’;³²
2. The Oslo Ministerial Declaration by the Ministers of Foreign Affairs of Brazil, France, Indonesia, Senegal, South Africa, and Thailand;³³
3. A strategy paper by the Government of the United Kingdom, Health is global: a UK Government strategy 2008–13 (HM Government, 2008);³⁴
4. A paper by Jones of the United States Department of State, ‘New Complexities and Approaches to Global Health Diplomacy: View from the U.S. Department of State’.³⁵

As mentioned above, we assumed that states will only engage in global universal health coverage if it serves their own interests. That was an essential criterion for the selection of the four key documents: they provide arguments for concerted global action for health in poorer countries that appeal to the self-interest of the countries potentially providing it: the richer countries. We are aware of the fact that this approach is somewhat reductionist. It excludes at least one political economy argument: that policy-makers are influenced by the expressed opinions of

their constituencies—the people who will re-elect them or not—and these people may be motivated by things other than pure self-interest. For the sake of methodological consistency, we limited our research to the arguments made in these documents, and we tried to validate or invalidate the underlying claims. This approach has the additional advantage of providing a kind of ‘worst case’ point of departure: if based on the assumption of self-interested states a case can be made for global universal health coverage, that case will only become stronger when more ethical values are added to it. We should add here that at least three of the arguments made in the four key documents cannot be reduced to the pure self-interest of states.

These four documents do not use exactly the same terminology, so we formulated a common terminology that captures the key ideas behind the arguments advanced. Some considerations are used as a single consideration in one document, and disaggregated into two or three separate (narrower) considerations in another document. For the sake of precision, we used the narrowest descriptions, even if that creates overlaps and some redundancy. Table 1 below lists 10 arguments for concerted global health action that is in the interest of countries potentially providing the required assistance, and indicates from which of the four documents they were extracted (the numbered columns refer to the documents mentioned at the beginning of this sub-section).

Table 1. Arguments for concerted global health action in the interest of the countries providing the required assistance:

Arguments	1	2	3	4
Concerted global health action helps reducing the risk of communicable diseases spreading	X	X	X	X
Concerted global health action can improve social cohesion and reduce the risk of political instability and armed conflict		X	X	X
Concerted global health action creates diplomatic goodwill	X	X		X
Concerted global health action can ease undesired pressure for migration				X
Concerted global health action contributes to economic growth	X	X	X	X
Concerted global health action creates a market for health goods and services	X			
Concerted global health action can have a positive impact on the environment		X		
Concerted global health action is needed to realize the human right to health		X	X	
Concerted global health action is needed for human security		X	X	X
Concerted global health action is needed because health is a global public good	X			

In the remaining part of this section, we will analyze these arguments, and investigate whether they are supported by scientific evidence.

II.3. Discussion of arguments for concerted global health action (in the interest of countries providing the required assistance)

II.3.1. Can concerted global health action reduce the risk of communicable diseases spreading?

The claim that concerted global health action can be an effective way for richer countries to protect their citizens against communicable diseases spreading from other countries seems undisputed. There is a long history of international cooperation, driven by the objective of

controlling communicable diseases. The World Health Report 2007, 'A Safer Future: Global Public Health Security', explores this consideration in depth and at length.³⁶

The acknowledgment of this consideration is one of the reasons why, according to Fidler, we are witnessing "a political revolution—the political revolution that has occurred in the area of health as an issue in international relations."³⁷ Wilson uses a sharp metaphor: "Canada should formulate a foreign and domestic policy focused on establishing health security at national and international levels. Like the mission in Afghanistan this policy will involve taking action abroad to tackle security risks at their source."³⁸

The undisputed character of this claim does not mean that it is uncontroversial. Concerns about communicable diseases may lead to global health action focused on protecting the inhabitants of rich countries. Labonté argues: "Health as national security is consistent with nation-states' often explicit duties to protect their citizens from foreign risk by guarding their borders, whether the 'invaders' are pathogens or people. It has also, post-SARS, given long-neglected public health measures more political clout and fiscal resources, at least in many high-income countries. (Public health systems in many low-income countries continue to languish.) But it has also led to a distortion in global health risk and response and elides dangerously with repressive political measures in the 'war on terror'."³⁹

Concerted global health action as a means of protecting inhabitants of richer countries against communicable diseases may not only lead to a focus on communicable diseases, but also to a focus on surveillance and perhaps containment measures, without treating the people already infected.

If this claim is to be used as an argument for global universal health coverage, it would require evidence that investing in robust health systems is more effective in containing disease than waiting for new epidemics and then launching surveillance and containment measures. That is what the World Health Report 2007 suggests: "These 57 countries, most of them in sub-Saharan Africa and South-East Asia, [facing a dramatic shortage of health workers] where are struggling to provide even basic health security to their populations. How, then, can they be expected to become a part of an unbroken line of defence, employing the most up-to-date technologies, upon which global public health security depends?"³⁶ It seems self-evident, but can it be backed by evidence?

Additional research

It may be possible to develop a model that allows a comprehensive comparison of the cost of an intervention following the outbreak of a new epidemic with the cost of permanently upgrading and supporting health systems.

II.3.2. Can concerted global health action enhance national and global social cohesion?

Could global universal health coverage be a "neglected counterterrorist measure", as Horton implies?⁴⁰ The High-level Panel on Threats, Challenges and Change explains one element of this argument: "International terrorist groups prey on weak States for sanctuary. Their recruitment is aided by grievances nurtured by poverty, foreign occupation and the absence of human rights and democracy; by religious and other intolerance; and by civil violence—a witch's brew common to those areas where civil war and regional conflict intersect."⁴¹

McInnes and Lee explain the other element: "Poor health provision may contribute to social disorder by highlighting inequalities; but it may also present a government as ineffective

regardless of whether it has the resources to deal with vital health issues. Poor health may also contribute to economic decline, fuelling discontent, by: forcing increased government spending on health as a percentage of GDP; reducing productivity due to worker absenteeism and the loss of skilled personnel; reducing investment (internal and external) because of a lack of business confidence; and by raising insurance costs for health provision."⁴²

The preeminent example of an international effort to improve health that seems partly inspired by a desire to contain terrorism is the American President's Emergency Plan for AIDS Relief (PEPFAR). Several scholars assert that PEPFAR was, at least to a certain extent, a reaction to the September 11, 2001, terrorist attacks against the U.S.A. and the fear that the AIDS epidemic would destabilize countries and create breeding pools for terrorism.^{43/44} Dietrich, however, disagrees with this analysis and argues that "as AIDS gained prominence on the U.S. agenda, President Bush moved away from the formula of AIDS as a security problem", and "[i]n Bush's eyes, AIDS relief is tied to a religious obligation to help the suffering because all humans are God's creations".⁴⁵

In any case, in a synthesis paper of the AIDS, Security and Conflict Initiative (ASCI), Barnett concludes that "the evidence for any clear relationship between state fragility and HIV is thin to nonexistent".⁴⁶ But he also concludes that all studies on which the ASCI synthesis was based "point towards a conclusion in a different direction, which is that the governance *response* to HIV/AIDS epidemics has the greatest potential to have an impact on state fragility, either by strengthening governmental institutions or by undermining them". As de Waal writes: "Those normative frameworks and intellectual paradigms [about "emergent infectious disease epidemics, several state collapses in Africa, and the collapse of the USSR"] drove global responses, and in turn influenced the trajectory of the HIV/AIDS pandemic and shaped the landscapes of international security and governance".⁴⁷

Another body of evidence in support of the claim that global universal health coverage would enhance national and global social cohesion, can be found in critical assessments of the 'Health as a Bridge to Peace' approach.⁴⁸ Freedman argues that core social institutions, like health systems, help define how people experience poverty.⁴⁹ If promoting health helps countries to emerge from conflict, or to stabilize peace, then logically efforts to improve health can help to avoid countries sliding towards conflict. What is the evidence?

Ranson and colleagues argue that "there is no robust evidence to support the assertions that equitable [health] service delivery can stabilize states, and much more research on this topic is needed".⁵⁰ Grove and Zwi argue that the lack of robust evidence could be due to shortcomings with the present tools to examine the impact of health improvement efforts on stability, and propose a 'Health and Peace Building' filter: "a tool can help to move us beyond inputs and outputs to examining processes, relationships, and the indirect consequences of aid programmes." Piloting the Health and Peace Building filter within projects in the Solomon Islands, Sri Lanka, and Timor Leste "reinforced the importance of focusing attention on the nexus between health and peacebuilding: there appeared to be definite scope for enhanced understanding and practice".⁵¹

Country case studies suggest that improving health services can promote social cohesion in post-conflict countries. Commenting on post-conflict recovery in Sierra Leone and Liberia, Humphreys and Richard mention: "A willingness to be identified as a citizen in return for access to (say) basic health or education would help convey to the larger mass of vagrant civilian youth a similar sense of belonging."⁵² The UNDP report on 'Post-Conflict Economic Recovery: Enabling Local Ingenuity' emphasizes the importance of reinvesting in human capital and, in doing so, "to take into account and address the inequities in societies that may have contributed to conflict dynamics in the first place", citing Mozambique as an example: "In Mozambique, for instance, the distribution of food and the provision of health services to previously inaccessible areas played an important role in decreasing tensions and restoring freedom of movement. In an attempt to

tackle historical imbalances in service provision, initial reconstruction was focused on rural areas and less privileged communities.”⁵³

Could the conflicts in Liberia, Mozambique, and Sierra Leone have been avoided, if international cooperation had realized universal health coverage? That question is impossible to answer. However, in an overview of the available evidence about improving health and state building, Kruk and colleagues argue that “Trust (and distrust) operate at many levels, from the microdynamics of the provider-patient interaction, to the overall relationship between a health facility and the community in its catchment area, to a citizenry’s general perception of the trustworthiness of government in fulfilling its obligations”.⁵⁴

If it could be demonstrated that concerted global health action can reduce the risk of armed conflicts, it would provide a strong argument for concerted global health action. But would it be an argument for global universal health coverage, or would it lead to a focus on so-called ‘fragile states’? The Center for Strategic & International Studies argues that from a security perspective, “any increase in assistance levels ought to be spread more purposefully throughout the world, rather than merely in three strategic countries or one strategic region”, because “[w]hat is paramount is the signal America sends globally—that we want the world to share in our prosperity, and we want our aid to address local aspirations”.⁵⁵

Additional research

Almost all studies mentioned in this point highlight the lack of robust evidence. If the argument that concerted global health action can improve national and global social cohesion is to be used as an argument for global universal health coverage, more research is needed. The ‘Health and Peace Building Filter’ used by Grove and Zwi appears to be adapted to the complexity of the argument.⁵¹

II.3.3. Can concerted global health action create diplomatic goodwill?

Health diplomacy is an emerging field of science, combining public health and international relations. Scholars working in this field highlight its potential for improving global health,^{56’57’58’59’60’61} but also warn against exaggerated optimism: “Some events seemingly bolster this view that global health has triumphed over foreign policy considerations. ... However, far from demonstrating a health-centric move “away from interests towards global altruism”, we argue that these examples actually demonstrate the enduring relevance of foreign policy interests to health diplomacy”.⁵⁶

As most health diplomacy literature draws on arguments mentioned above and hereafter, we hesitated about including it as a disaggregated argument. However, it provides links with the more conceptual arguments developed later in the paper, and it advances a particular argument that is difficult to assess.

Let us first briefly explain the link with the conceptual arguments. Feldbaum and Michaud argue: “Countries are increasingly using health initiatives as a means to improve security, project power and influence, improve their international image, or support other traditional foreign policy objectives”.⁵⁶ Brainard argues: “Foreign assistance variously serves to advance national security, national interests, and national values”.⁴³ In as much as human rights, human security and global public goods represent values shared by many countries, it could be a foreign policy objective of these countries to make sure these values are broadly shared. Leading by example would then be a matter of ‘enlightened self-interest’.

Several elements of the particular argument that we find difficult to assess are mentioned in the above quote from Feldbaum and Michaud.⁵⁶ What does it mean for countries to “improve their international image”? Is it a stand-alone good, driven by the pride of constituencies, who would rather belong to a nation or state that is appreciated in the rest of the world, or is it something that can and is intended to be used for other purposes? What are the “foreign policy interests”? Are they the ones pursued through a better international image? What are they worth?

Armitage and Nye argue—about the USA, but many countries could make the same reflection—that: “America should have higher ambitions than being popular, but foreign opinion matters to U.S. decisionmaking. A good reputation fosters goodwill and brings acceptance for unpopular ventures. Helping other nations and individuals achieve their aspirations is the best way to strengthen America’s reputation abroad.”⁵⁵

Surely, global universal health coverage would be highly appreciated by millions of people who currently have no access to basic health goods and services, and consequently improve the image of the countries participating in international cooperation for global universal health coverage. However, without more explicit assumptions about the benefits from, for example, “unpopular ventures” that could be accepted,⁵⁵ it is difficult to assess to what extent this argument outweighs the cost of engaging in global universal health coverage.

II.3.4. Can concerted global health action ease undesired pressure for migration?

Jones briefly mentions that one of the objectives that could be achieved through improving global health would be to “ease pressure for migration”.³⁵ There seems to be “rising concern about a potential flood of African migrants bridging Europe’s southern moat and washing under America’s door”.⁶² In keeping with the ethos of this paper, we will not discuss whether this argument is ethically objectionable or not, but restrict ourselves to suggesting that if concerted global health action could decrease pressure for migration, many richer countries would be interested in supporting it.

How would concerted global health action ease pressure for migration? The most obvious hypothesis would be that some migrants are motivated by seeking better health care than they can obtain in their home countries. But this hypothesis is not supported by evidence. On the contrary, several studies report a so-called ‘healthy migrant’ or ‘healthy immigrant’ effect: healthier people are more likely to migrate than people struggling with their health.^{63’64} This refutation is in line with the findings of Hatton and Williamson, that “emigration rates out of really poor countries are very low, while they are much higher out of moderately poor countries”, and one of the explanations they provide is that extreme poverty constrains migration since financing investment in a long-distance move is difficult for the very poor.⁶⁵ Likewise, poor health may constrain migration. One could therefore cynically conclude that in as much as they want to ease pressure for migration, richer countries should not engage in concerted global health action.

According to Hatton and Williamson, the two main factors driving emigration from Africa are the same that drove emigration from Europe in the nineteenth century: “real wage gaps between sending and receiving regions and demographic booms in the low-wage sending regions”.⁶² Extreme poverty constrains migration only temporarily; eventually migration takes off—as the first successful adventurers send remittances home to support family members and friends to join them—and decreases when the wage gaps between sending and receiving regions decreases. Demographic booms fuel the process, as they lead to large numbers of available workers unable to find a job. As we will discuss further below, concerted global health action seems to have the potential to encourage economic growth—and thus reduce the wage gaps—and the potential to stabilize population growth. So indirectly, concerted global health action

could ease migration pressure, that is: if the arguments that concerted global health action can increase prosperity and contribute to the stabilization of population growth are valid.

II.3.5. Can concerted global health action contribute to economic growth?

The World Bank's World Development Report 1993, 'Investing in Health', made the case that increased health expenditure in developing countries could contribute to faster economic growth.⁶⁶ It marked the beginning of a paradigm shift, described by Mills and colleagues: "In recent years there has been a significant shift in the attention being paid to health within development policies. Once seen as a 'non-productive sector', to be given resources only to the extent permitted by economic growth, it is now viewed as an important driver of economic growth."⁶⁷

What is the evidence? Rivera and Currais, in 1999, provided empirical evidence in support of the paradigm shift, showing a positive effect of improved health on economic growth, not merely a 'reverse causation' (economic growth having a positive effect on health).⁶⁸ The claim that international health financing would yield a substantial return on investment for all countries was forcefully made by the WHO Commission on Macroeconomics and Health. The Commission estimated that a sustained investment of US\$66 billion per year in priority health interventions in the poorer countries of the world would yield direct benefits exceeding US\$500 billion per year.¹⁶

Not everyone agrees with the analysis of the WHO Commission. Acemoglu and colleagues argue that "investments [in the health of less-developed populations] are highly desirable on humanitarian and social grounds, but the evidence that these investments will lead to rapid economic development is weak".⁶⁹ They offer an alternative hypothesis for the finding that improved health predicts economic growth: European migrants were reluctant to settle where the health environment was poor, and settlement by European migrants caused economic growth: hence poor health environments lead to poor economic growth, through less significant settlement by European migrants. Apart from the fact that this hypothesis might overestimate the positive impact of settlement by European migrants on economic growth, it does not refute the hypothesis that improved health leads to economic growth, it only provides an additional causation: it could be that poor health works as a disincentive for foreign investment (accompanied by migration or not) and that improved health attracts foreign investment.

Acemoglu and Jones also found that the economic growth resulting from increasing life expectancy is offset by population growth: wealth per capita decreases.⁷⁰ Bloom and Canning argue that the initial population growth is usually short lived, as "[f]alling infant mortality usually leads to a fall in fertility, which stabilizes population numbers and generates a demographic dividend through a very low level of youth dependency".⁷¹ They conclude that "[m]acroeconomic evidence for an effect on growth is mixed, with evidence of a large effect in some studies", and further highlight three mechanisms through which "health may be not only a consequence but also a cause of high income":

- "Healthy workers lose less time from work due to ill health and are more productive when working";
- "Childhood health can have a direct effect on cognitive development and the ability to learn as well as school attendance";
- "A longer prospective lifespan can increase the incentive to save for retirement, generating higher levels of saving and wealth".⁷¹

We would add two mechanisms:

- A poor health environment can be a disincentive for foreign investment;⁶⁹

- Social health protection, knowing that health care will be available and affordable when needed, may increase risk-taking entrepreneurial behavior.⁷²

Additional research

The evidence for the claim that international health financing can contribute to economic growth seems quite compelling. However, the research remains somewhat fragmented (different causal links are investigated separately); more comprehensive research approaches would be useful.

II.3.6. Can concerted global health action create a market for health goods and services?

The report of the Board on International Health considers health in developing countries as “a market with an unfulfilled potential”.³² Could this be an argument for richer countries to contribute to global universal health coverage, expecting the return on investment to be the export of health goods and services?

Examining recent international health financing, McCoy and colleagues found that: “a large amount of other global health spending is directed at the purchase of medicines and other commodities from private companies.”⁷³ That does not mean, however, that the private companies benefiting from this financing are from the countries providing the financing. In a 2001 paper arguing that patents did not constrain the provision of antiretroviral treatment in Africa, pharmaceutical companies declared which patents they claimed to possess on antiretroviral medicines.⁷⁴ By comparing only the purchases of the fixed dose combination of lamivudine-stavudine-nevirapine—which became one of the most popular treatment regimes—as declared by the Global Fund’s online purchase price reports, we can easily identify 19 countries in Africa that purchase or purchased generic versions of this medicine, although the originator companies had claimed to have a patent on at least one of the components (see Annex 2). This analysis suggests that a kind of informal compulsory license regime emerged.

We cannot exclude the possibility that the interests of pharmaceutical companies influence choices about the use of international health financing. The Council of Europe recently launched an investigation into the way WHO managed the H1N1 influenza, suspecting that its approach was influenced by pharmaceutical companies.⁷⁵ However, as a potential argument for global universal health coverage, the claim that the investment would return via profits of pharmaceutical companies seems rather weak: not only would seeking this return distort the objective of universal health coverage, it would at best succeed in returning a fraction of the investment. If the motivation for richer countries providing the required assistance for global universal health coverage were to stimulate their domestic economies, domestic stimulus efforts would seem a wiser choice.

II.3.7. Can concerted global health action contribute to protecting the environment?

This argument is mentioned in a hypothetical manner in the Oslo Ministerial Declaration: “Human health and the environment are both outcomes of complex systems that exist in dynamic balance. Given the severity of health threats related to climate change, biosecurity, and biosafety, the linkage between global health and environment should be considered”.³³ If it seems clear that a degrading environment has negative impacts on health, it highlights the importance of measures to slow environmental degradation. Can an argument be made that international health financing might have a positive impact on the environment?

The Millennium Ecosystem Assessment points at the inverse relation, albeit in passing (and surprisingly under the heading education, not health): “A better-educated population is likely to be in a stronger position to protect, preserve and restore essential ecosystem services, including by accelerating the demographic transition in countries where fertility rates remain high or above replacement level”.⁷⁶

Our research suggests that even the scholars concerned with the health impacts of climate change have so far only superficially examined the potential climate change impacts of improved health. McMichael and Butler, for example, briefly mention that “Good health and social development slows population growth” in an illustration accompanying their paper, but not in the text.⁷⁷ This is surprising as the evidence that desired fertility levels are strongly influenced by perceived infant mortality levels seems undisputed.^{78’79’80’81} This phenomenon is known as the ‘demographic transition’: when infant mortality goes down, the population starts to grow rapidly, but after a while it stabilizes because parents choose to have fewer children. Global universal health coverage could have a double impact on fertility rates: reducing desired fertility rates and providing the birth control methods needed to act upon such desire. Lee cautions about heightened expectations: “The causal implication of such statistical associations is far from obvious, however, particularly because there is no straightforward mechanical relationship between mortality decline and a fertility response. For instance, in the last 40 years the onset of fertility transition has occurred in settings where infant mortality is 150 per thousand live births and survival at older ages is correspondingly low. In other settings, birth rates have remained unchanged until infant mortality dropped to 50 per thousand”.⁷⁹

To put this in perspective, according to the latest WHO estimates, in 2008 there were 52 countries with an infant mortality level above 50 per thousand live births, and in 10 of those infant mortality was higher than 100 per thousand live births (Annex 3). Even the lower pivotal point is not entirely out of reach for most countries. The comment by Haines and colleagues that “policies to accelerate the demographic transition and thus reduce population growth can have a major effect on greenhouse-gas emissions in the long term”⁸² thus seems warranted.

Estimates about the costs of compliance with the Kyoto Protocol on greenhouse gas emissions vary enormously—between 0.5% and 5% of de GDP of high-income countries.⁸³ Even when considering only the lower estimates, there seems to be a very strong case for global concerted health action, on the basis of its potential to contain the future ecological footprint of the global population.

Additional research

Multi-disciplinary research combining the latest knowledge on demographic transition with the latest knowledge on the long-term cost and benefits of containing climate change might strengthen this argument as a solid argument for global universal health coverage.

II.3.8. Is concerted global health action is essential to realize the right to health?

The argument that concerted global health action is required to realize the right to health might seem somewhat out of place in a list of claims referring to the self-interests of countries that would provide international health financing. Surely, realizing the right to health in poorer countries would be in the interest of the people living there. But would it serve the interests of the countries providing the required assistance, in a way that is different from the arguments above?

As mentioned above (point II.3.3.): “Foreign assistance variously serves to advance national security, national interests, and national values”.⁴³ It would serve the interests of all countries if all other countries were compliant with the entire body of human rights law. It would mean a world where freedom of thought and expression, and other civil and political human rights would be guaranteed to all, and where health, education and other economic, social and cultural human right would be fulfilled as well. However, the human rights discourse of richer countries is often met with skepticism in poorer countries. Mahbubani, for example, compares the focus on civil and political rights in present human rights advocacy and the relative neglect of economic, social and cultural rights—including the right to health—with “affluent, well-fed, and well-intentioned onlookers”, criticizing the captain of a boat overcrowded with hungry and diseased passengers for not respecting freedom of speech, but refusing to help provide food and health care.⁸⁴ If richer countries judge it to be in their self-interest to promote human rights, it would be in their self-interest to promote all human rights, including the ones to which they would have to contribute financially or through other means of international cooperation.

We find it problematic to reduce the right to health to an argument for concerted global health action serving the interests of countries that would provide assistance, but would argue that even from such a narrow perspective, the argument remains valid.

Additional research

Sen became famous for his work on the relationship between democracy and famine. In short, he argued that major famines do not occur in democratic countries, where freedom of speech is guaranteed and decision makers are held accountable: civil and political human rights thus lead to the realization of economic, social and cultural human rights.⁸⁵

The ‘capability’ approach he uses also implies causation in the opposite direction: poverty and poor health reduce the capability of individuals take part in the ‘public life’, which is essential for democracy. It would be interesting to study countries where major public health progress occurred to assess whether that progress went hand-in-hand with progress in the realization of civil and political human rights, and to which extent both processes were mutually reinforcing. Historical research may provide the best tools to answer a question like this.

II.3.9. Is concerted global health action essential for human security?

The Commission on Human Security defines human security—or its objective—as “to protect the vital core of all human lives in ways that enhance human freedoms and human fulfillment”.⁸⁶

Most proponents of human security trace its roots back to the UNDP Human Development Report 1994, ‘New dimensions of human security’, which mentions: “In the final analysis, human security is a child who did not die, a disease that did not spread, a job that was not cut, an ethnic tension that did not explode in violence, a dissident who was not silenced”.⁸⁷ From its conception, the use of a broad human security argument to validate concerted global health action appealed to a combination of countries’ self-interest—containing disease, avoiding conflict—and more altruistic values. ‘Health security’ seems to have emerged, in recent years, as specific objective of human security.⁸⁸⁸⁹ Frenk argues: “Beyond immediate response to the crisis, health security must be grounded on a truly universal package of guaranteed benefits or entitlements, comprising a set of essential services applied to all in the world”.⁸⁹

This broad definition of security is not uncontroversial. The Human Security Centre of the University of British Columbia issues its own Human Security Reports, in which it deliberately adopts a narrower definition of human security that focuses on “violent threats to individuals”,

not the broader definition of “hunger, disease and natural disasters”.⁹⁰ While the authors contend that “the two approaches to human security are complementary rather than contradictory”, they lash out at the broader approach: “A concept that lumps together threats as diverse as genocide and affronts to personal dignity may be useful for advocacy, but it has limited utility for policy analysis. It is no accident that the broad conception of human security articulated by the UN Development Programme in its much-cited 1994 Human Development Report has rarely been used to guide research programs.”⁹⁰

This is a serious critique. On the other hand, we would argue that the tension created by the broader human security approach constitutes its added value, by emphasizing the connections between different elements of human security and between different parts of the world. For example, connecting the dots between child mortality in one part of the world, desired fertility, overpopulation, climate change and floods in a different part of the world, is an exercise that would fit well in a human security approach.

Additional research

There is a lot of research that would fit within the human security paradigm, but that is not at present framed as such. For example, we noted above (point II.3.7.) that the evidence about perceived child mortality as influencing fertility seems rather compelling, and that the observation that policies to reduce child mortality could have a major impact on greenhouse-gas emissions therefore seems warranted, but that the connection between both is not often made.

Rather than being a stand-alone argument of which the validity could be verified, the human security argument seems to provide a useful framework under which the validity of other arguments can be verified, and their relevance highlighted.

II.3.10. Is concerted global health action needed because health is a global public good?

The report of the Board on International Health argues that: “The basic medical knowledge being accrued by the National Institutes of Health and the expertise in disease surveillance and prevention of the U.S. Centers for Disease Control and Prevention are unique national resources that help to create and sustain the international public good.”³²

This statement may reflect a somewhat narrow vision of what international public goods or global public goods are; nonetheless it advances the claim that health is a global public good, which provides an argument for global universal health coverage.

The 2006 report of the International Task Force on Global Public Goods was entitled ‘Meeting Global Challenges: International Cooperation in the National Interest’.⁹¹ Therefore, like the human security approach, the global public goods approach intends to appeal to a combination of national self-interest and more generous intentions: it advocates cooperation for the common good. However, although the report dedicates a chapter to health, it is entirely about communicable diseases. When judged by this report alone, the global public good argument adds nothing to the claim that concerted global health action can be a smart way for countries to protect their inhabitants from communicable diseases by fighting them abroad.

Before jumping to that conclusion, let us first try to explain what public goods are, in the area of health. Dunn and Ross identify two frequently used criteria, and a third less frequently used criterion:

- “*non-rivalness*, which means that once a good is supplied to one person, it can also be supplied to all other persons at no extra cost”;

- “*non-excludability*, whereby having provided the good to one person it is impossible to exclude any other person from its benefits”;
- “*non-rejectability*, which means that once a good is supplied it must be consumed equally by all”.⁹²

The containment of SARS is an example of a public good. From the perspective of the inhabitants of a country where SARS never occurred (because of particular interventions), the absence of SARS is:

- A *non-rival* good: the interventions necessary to protect a single inhabitant from SARS are automatically protecting every other inhabitant at no extra cost;
- A *non-excludable* good: no inhabitant can be excluded from the benefit of the absence of SARS;
- A *non-rejectable* good: even the inhabitants who do not want to be protected against SARS are protected anyhow.

Long and Woolley argue that “In the economics literature, public goods are significant because they lead to market failures and so justify the government's role in addressing that failure”.⁹³ Most inhabitants of a country would be willing to pay something to keep SARS out, but nobody would be willing to pay the entire bill, knowing that everyone else would automatically be protected and would therefore no longer have an incentive to pay a contribution: this is the problem known as ‘free riding’. Hence, the government intervenes and through taxation makes everyone contribute.

Would health (beyond containment of communicable diseases) qualify as a global public good? Long and Woolley argue it would not: “We wait (or pay) for surgeries precisely *because* health care is rival (a surgeon cannot operate on two people simultaneously) and excludable (a hospital can choose whom to admit)”.⁹³

Chen and colleagues acknowledge that “[b]ecause of externalities, the control of communicable diseases is a public good, but treatment for noncommunicable diseases and injury is mostly private”.⁹⁴ However, they argue that “this rigid divide appears to oversimplify a more complex situation”. By focusing their attention to causes of non-communicable diseases—unhealthy habits like tobacco consumption and excessive alcohol consumption, spreading like infectious diseases—they make the case for a broader interpretation of health as a global public good. An international ban on publicity for tobacco would be a non-rival and non-excludable good: as soon as it protects some, it protects all, at no extra cost. Arhin-Tenkoran and Conceição also make the case for a broader view on health as a global public good, by focusing on the externalities of poor health in poorer countries; including not only the risk of communicable diseases spreading, but also:

- “*Large disease burdens harm economic growth and increase poverty. ... These effects also limit investment and trade opportunities for firms in industrial countries*”;
- “*Large burdens of disease also threaten political stability and foster social unrest, with possible global consequences*”;
- “*Globalization risks losing its legitimacy, because disease-stricken people in developing countries are likely to feel disenfranchised and abandoned*”.⁹⁵

Avoiding these externalities would be a global public good: once avoided for some, they are avoided for all.

As such, the health as a global public good argument draws on the particular arguments above: concerted global health action can avoid the externalities of poor health, like the spread of communicable diseases, social and political instability, overpopulation... But it adds a particular challenge, as it highlights the problem of free riders. All countries may want to contribute to concerted global health action, because of its expected externalities, for their own interest. But all countries will be tempted to let others pay for it.

Additional research

Long and Woolley comment on the use of the broader application of the global public goods concept that “such banalities belong in a political manifesto, not a piece of analytical research.”⁹³ We are not convinced, we think the broader application of the global public goods concept does belong in analytical research, but we found very little global public goods research that goes beyond conceptualization.

In ways very similar to the human security argument, the health as a global public good argument might be more useful as a framework to examine the validity of other arguments and to highlight their relevance.

II.4. Conclusion

Using the four key documents mentioned above (point II.2.) we extracted 10 arguments for concerted global health action that is in the interest of countries providing the required assistance. Seven of them can be qualified as distinct stand-alone arguments; three are more conceptual arguments (building on the distinct arguments, while adding a specific dimension).

Out of the seven distinct arguments, we feel that five are compelling (even if additional research could make some of them stronger, or reveal that they are not as compelling as their proponents claim):

- Concerted global health action can help to protect the inhabitants of countries providing the required assistance from communicable diseases;
- Concerted global health action can help to protect inhabitants of countries providing the required assistance from the spillover effects of political and social instability elsewhere;
- Concerted global health action can “ease pressure for migration”, although indirectly, through its potential impact on economic growth;
- Concerted global health action can encourage economic growth;
- Concerted global health action can contribute to protection of the environment, but only in the long run, by reducing child mortality levels and desired fertility.

There is one argument that we found difficult to assess (concerted global health action creates diplomatic goodwill towards the countries providing the assistance), and one we found rather unconvincing (concerted global health action creates a market for companies based in the countries providing the assistance).

Do these arguments constitute a solid case for global universal health coverage? Not if one considers them separately. In trying to protect their inhabitants from communicable diseases, richer countries would be willing to co-finance particular interventions, not all universal health coverage. In trying to protect their inhabitants from the spillover effects of social and political instability, richer countries would be willing to assist fragile states, not states where the risk is limited. In trying to offer their inhabitants the benefits of economic growth elsewhere, richer countries would focus on poorer countries perceived as having the biggest growth potential; and in trying to protect the global environment for their own inhabitants, richer countries would focus on poorer countries where the demographic transition has not yet been completed.

However, we believe that when taken together all of these arguments appear to make a strong case for global universal health coverage. Rather than pursuing each distinct benefit separately, it might be a lot more efficient to pursue them together. Thus even from the national self-

interest perspective, excluding altruistic motives, supporting global universal health coverage seems to make sense for wealthier countries.

The three more conceptual arguments help to combine the distinct ones.

- Approaching health as a human right links global universal health coverage with the entire body of human rights. As rights are mutually reinforcing, the promotion of each right serves to reinforce the others. But approaching human rights in a more limited way that does not include health among those rights, (for example, promoting democracy without helping to provide education and health care,) lacks credibility and provides limited benefits.
- Approaching health as a human security issue helps explain how not addressing health insecurity in one part of the world may ultimately undermine human security in a different part of the world.
- Approaching health as a global public good improves our understanding of how all people would benefit from the externalities of improved global health, or from avoiding the present negative externalities of poor health.

If the case for global universal health insurance seems strong, why has it not become a reality? Obviously, the methodology we used—looking for arguments for concerted global health action, and trying to verify their validity—does not provide the answers to that question. The obvious answer would be that richer countries have other priorities, but given the rather modest level of assistance required, according to available estimates (see Annex 1) we do not find this answer convincing.

Approaching health as a global public good may provide the beginnings of an answer. The concept of public goods was elaborated to identify goods for which everyone would be willing to pay, in principle, but for which most people would be reluctant to pay because they would rely on others (free riding behavior). Hence, a public good calls for government intervention in the market, to ensure that everyone contributes. At the national level, there are governments that can do exactly that. At the global level, there is no government. As Collier argues: “The absence of a world government hugely constrains the scope for using the normal instruments of political power: public goods provision, taxation and regulation.”⁹⁶

Would global universal health coverage require a global government? The very idea may scare away people who are otherwise convinced about the need for global universal health coverage. In the third and final section of this paper, we will argue that global universal health coverage does not require a global government, but that it requires the management of health interdependence between countries, while trying to preserve country autonomy as much as possible. We will also argue that this challenge is not new, and that most of the paradigm shifts in international health financing practices can be understood as attempts to manage health interdependence between countries while trying to preserve country autonomy.

Section III. How could global universal health coverage be achieved—managing mutual dependence while trying to preserve country autonomy?

III.1. Introduction

The arguments reviewed under the second section of this paper, when taken together, seem to provide a strong case for global universal health coverage, as we defined it in the first section of the paper. The 1978 Declaration of Alma Ata, which recognized health as a human right but also as a worldwide social goal,⁹⁷ could have paved the way for global universal health coverage, and global universal health coverage might have become a reality by the year 2000. This did not happen.

Proponents of the Declaration of Alma Ata will argue that the concept of ‘selective primary health care’ undermined the ideals of the Declaration of Alma Ata.^{97,98} We would argue that the Declaration of Alma Ata itself contains an ambiguity that may have paved the way for selective primary health care. While Baum argues that the Declaration of Alma Ata was based on several understandings including the “acceptance of the inter-dependence between countries”,⁹⁷ the Declaration also mentions that health care should be made accessible at “a cost that the community and country can afford to maintain at every stage of their development *in the spirit of self-reliance and self-determination.*”⁹⁹

There is a tension between *inter-dependence* and *autonomy* (*autonomy* used here as shorthand for “the spirit of self-reliance and self-determination”): if one aims for *autonomy*, international health financing is undesirable; acknowledging *inter-dependence* opens the door for international health financing but creates challenges of *country ownership* and *accountability*.

One could argue that the proponents of selective primary health care emphasized autonomy over inter-dependence—albeit a rather paternalistic approach to country autonomy: telling poorer countries what to do to become autonomous—as they calculated that “total primary health care” was “unattainable in terms of its prohibitive cost and the numbers of trained personnel required”, implicitly excluding the option of open-ended international health financing.¹⁰⁰

What is so important about country autonomy that it may cause countries to reject reliance on other countries, even if the consequence of that rejection is otherwise preventable death? We would argue that true individual self-reliance is an illusion; in reality everyone relies on others at some point in their life. Within the context of a country, mutual reliance on ones fellow residents is acceptable. Mutual reliance between people living in different countries, however, seems deeply problematic.

In this section, we will first explore why mutual reliance within borders of a state or nation or country is fundamentally different from mutual reliance beyond borders. Referring to the theory of states as social contracts, we will explain why mutual reliance beyond borders requires giving up more individual autonomy than mutual reliance within borders requires.

Then we will explore how the recent practice of international health financing and its many paradigm shifts since the Declaration of Alma Ata can be understood in light of the quest for a balance between country autonomy and health inter-dependence between countries.

Finally, we will argue that global universal health protection requires a global social contract, which does entail a partial abandonment of national autonomy, for a benefit that eclipses the cost.

III.2. States seen as social contracts, and the desirability of country autonomy: theory

States can be seen as social contracts—as individuals agreeing to support an authority that collects contributions from all to provide goods and services to all:

- An army to provide protection against external enemies;
- Police and judicial systems to provide protection against enemies from within;
- Water, sanitation, roads, and other infrastructure beneficial to all;
- Education, health care, pensions, and other social services, to provide protection against the hazards of life and the hazards of the market.

Rawls' book "A Theory of Justice" is a well-known recent example of 'contractarianism' (the philosophical school of thought that embraces the concept of states as social contract). Rawls argues that if representatives of civil society groups, under a "veil of ignorance" (without knowing which group they represent), were to elaborate a social contract, that contract would include respect of essential freedoms and a minimum level of "distributive justice". In a Rawlsian society, all would contribute to efforts that guarantee equal opportunity to all, as a condition for a stable society.¹⁰¹

Some of Rawls' intellectual heirs extended his arguments to the global level. A global society, they argued, would also require respect for essential freedoms, and a minimum level of distributive justice. Rawls dismissed these ideas in his "Law of Peoples".¹⁰² At the core of his rejection lies contractarianism: all peoples have a right to negotiate their own social contract; no people should be obliged to assist another people dealing with the consequences of the social contract it has chosen.

From the contractarian perspective, mutual reliance for health protection within the borders of a country requires giving up some individual autonomy. The authority will decide, to a certain extent, how much each individual contributes for health protection, and the authority will decide, to a certain extent, which health goods an individual will receive. (Only to a certain extent, as the public provision of health goods does not exclude the possibility that individuals choose to buy additional health goods privately.) But this abandonment of individual autonomy is—at least in principle—compensated for by participation in the decision making process.

Mutual reliance for health protection beyond borders of states requires giving up individual autonomy as well. Somewhere, a committee decides on a contribution from one country to be allocated to health goods provided to inhabitants of a different country. In the absence of a global government, an individual will—at least in principle—not participate in this process.

That is why the idea of a world composed of autonomous countries seems highly desirable: in the absence of a world government, it seems the only way to ensure that the individual can participate in the decisions that concern them.

III.3. The desirability of autonomous countries and its impact on international health financing: managing mutual dependence, while preserving country autonomy

The idea of a world composed of autonomous and democratically governed countries may be attractive, but when it comes to health it contains two flaws:

- Some countries are simply too poor to protect the health of their inhabitants without external assistance;
- Health inter-dependence between countries is real in both directions; even the richest countries cannot protect the health of their inhabitants without enabling other countries to protect the health of their inhabitants.

Therefore some countries seek assistance, but try to preserve their autonomy: they want to decide how the assistance will be used. Other countries are willing to provide assistance, but they want to preserve their autonomy too: they want to decide how the assistance will be used.

Ever since the Declaration of Alma Ata, the international community has tried to manage health inter-dependence between countries, without sacrificing country autonomy.

- The selective primary health care strategy pushed hard for country autonomy. It assumed that international health financing would decrease and promoted solutions that were considered affordable, even for the poorest countries.¹⁰⁰
- Although the selective primary health care strategy was embraced by many richer countries, they continued to finance projects within and outside the remit of selective primary health care. Project financing is a simple (or primitive?) way to manage health inter-dependence: in essence they are short-term contracts with a precise objective; both the donor and recipient country have to agree. According to LaFond, project funding also preserves the “myth of sustainability”; it is assumed that after the project funding term is completed, the project will continue but will now be domestically financed.¹⁰³ In that sense, project funding continued to aim for country autonomy, in the long run.
- Under project funding, country autonomy proved an illusion for countries at the receiving end (countries at the contributing end kept direct control). Poorer countries were not in a position to refuse projects, and some did not have the capacity to coordinate the many ongoing projects. During the nineties, sector-wide approaches or SWAps were introduced. The SWAp strategy intended to provide “increased health sector coordination, stronger national leadership and ownership, and strengthened countrywide management and delivery systems”.¹⁰⁴ SWAps can be seen as more sophisticated tools to manage mutual dependence. “Donors gain influence by participating in the SWAp, but sacrifice direct control.”¹⁰⁵ Richer countries no longer know exactly what purposes their assistance is used for (because it is pooled with contributions from other countries, and—under some SWAp arrangements—with domestic financing as well), but in return they participate in the decisions impacting the entire health sector of countries at the receiving end. It is not clear to what extent SWAp arrangements still aim for country autonomy, or accept health inter-dependence over a longer period. Given the fact that—according to World Bank estimates—34 countries rely for more than 20% of total health expenditure on external resources (Annex 4), we can assume a tacit agreement on continued mutual dependence.
- The nineties also saw the emergence of Public-Private Partnerships (PPPs) for health. By 2004, Buse and Harmer identified 23 “Global Public-Private Health Partnerships”; far less than the “100+” estimate advanced by some, but nonetheless an impressive list.¹⁰⁶ The narrow mandate of PPPs allows richer countries to finance exactly what they consider to be priorities, which seems to be an effective way of mobilizing international health financing,

but in doing so PPPs may “skew national priorities of recipient countries by imposing those of donor partners”.¹⁰⁶ PPPs adopted different forms of governance mechanisms, and each of them can be seen as an experiment in managing health inter-dependence. It is difficult to judge whether these governance mechanisms constitute an improved way of managing inter-dependence, as there is no ideal standard. For example, while Buse and Harmer note with concern the relatively limited representation of non-governmental organizations (NGOs) on PPP boards, one should also note that as far as we can tell NGOs are not included in SWAp governance mechanisms—and some may argue that is all the better as the government representatives are supposed to represent the people. But even without an ideal standard, the governance mechanisms adopted by some PPPs seem particularly interesting. The Global Fund’s grant-making mechanism is based on proposals elaborated by country coordination mechanisms (including a multitude of stakeholders), an independent technical review panel (judging proposals on their technical merits), and a board where ‘contributors’ and ‘implementers’ have an equal number of votes (and where technically sound proposals are approved for a financing agreement).¹⁰⁷

- The World Bank too can be seen as a tool to manage global health inter-dependence. Although not created for that purpose, since the end of the nineties “the World Bank has assumed the role of lead agency in the health sector, with WHO providing medical expertise or “technical support.””¹⁰⁸ The World Bank—in particular its ‘soft loan arm’, the IDA—has become one of the most important channels of international health financing. It has no particular governance body for the loans and grants it provides for health; therefore the general governance mechanism of the World Bank is one under which countries at the contributing end have a say in how contributions are raised and allocated. (Countries at the receiving end have an additional opportunity for influencing the allocations: at least in principle they can refuse a grant or loan.) As the boards of the World Bank—plural, because the International Bank for Reconstruction and Development (IBRD), the International Finance Corporation (IFC), and the IDA are different legal entities; in reality there is only one board—meet only once per year (World Bank, 2010) and have many issues to discuss.¹⁰⁹ Thus, one would not expect many countries to consider the World Bank as an international health financing channel where they can preserve country autonomy. Yet the IDA has a remarkably strong track record when it comes to burden-sharing between richer countries and long-term predictability of financing. (International Development Association, 2007) Perhaps this is due to the fact that on the boards of the World Bank, countries have voting rights in accordance with their shares: richer countries thus have a feeling of controlling the World Bank, even if most decisions are taken by World Bank staff. This reality may be displeasing to those who would like a fairer decision-making process; but it may also reflect the reality of the international political economy.
- Last but not least, the International Health Partnership, launched in 2007 and embracing other initiatives to become the IHP+, promotes “a single plan articulated by each developing country’s government”, intended “to ensure government ownership and decrease the potential for conflict between different actors.”¹¹⁰ The IHP+ was never intended to be a channel of international health financing, yet can be seen as an attempt to manage health inter-dependence. Although ensuring country ownership was the main objective, the IHP+ proposes “a consultative process involving the donors in the formulation of these plans.”¹¹⁰ Ideally, the IHP+ would provide an additional platform, where countries providing international health financing and countries receiving international health financing would agree on priorities, which would then simplify all the existing processes to manage inter-dependence, like SWAps, PPPs, and the World Bank. Three years down the road, the results of the IHP+ are disappointing.¹¹¹ Perhaps this disappointment can be attributed to the fact that the ‘single plan’ promoted by the IHP+ is inevitably based on the ‘greatest common denominator’ of all international health financing channels: pursuing each channel separately may allow poorer countries to get a little bit more out of each channel. An

alternative explanation is that the richer countries feel that they do not have a sufficient say in IHP+ processes, and therefore do not feel bound by their outcomes.

This overview is incomplete; it was not intended to be exhaustive, it was intended to be illustrative.

III.4. Conclusion

If the idea of global universal health coverage, as defined it in the first section of this paper, appears unorthodox, because of its intended reliance on international health financing and thus on an acceptance of mutual dependence and a willingness to manage it, this section demonstrates that managing mutual dependence in health is not a new challenge. In fact, ever since the Declaration of Alma Ata, the international community has struggled to manage health inter-dependence, while preserving country autonomy, through projects, SWAPs, PPPs, the World Bank and the IHP+.

And the international community may well continue its struggle. Hill understands global health governance as a “complex adaptive system”, and argues: “The ‘lesson’ of complexity theory is that change will continue, but that within that change, structures will emerge to meet new challenges, and, over time, be shaped by their interface with the system. Coalitions will continue to form to address perceived ‘gaps’ in the global health fabric—health systems’ constraints to achieving goals, inadequate representation of partner countries, unrealised financial commitments, policy misalignment, and neglected diseases.”¹¹²

Perhaps it is time to take stock of what has worked and what has failed, to combine the most promising elements of what has worked and to learn lessons from what has failed. The new momentum for *national* universal health coverage looks promising, but may be doomed to fail if it does not acknowledge that at least some countries will have to rely on international health financing; in other words, if it rejects *global* universal health coverage. Global universal health coverage can be managed, if everyone is willing to accept that for countries at the contributing and receiving ends, country autonomy is a political economy objective.

In a different background paper, one of us listed ten pragmatic arguments why a Global Health Fund—based on the existing Global Fund, with an expanded mandate—could be the best solution:¹¹³

1. Pooling international health financing allows more ambitious national health plans;
2. Pooling international health financing reduces the administrative burden for countries receiving the assistance;
3. Pooling international health financing encourages alignment with national priorities;
4. Pooling international health financing through something like the present Global Fund allows meaningful civil society participation;
5. Pooling international health financing increases the long-term predictability of international health financing;
6. Increasing the long-term predictability of international health financing encourages countries to increase total government health expenditure;
7. Increase total government health expenditure entails increasing domestic government health expenditure;
8. Pooling international health financing allows burden-sharing between richer countries (as a matter of discharging their international obligations arising from the human right to health);
9. Pooling international health financing reduces the possibility for richer countries to attach political strings to their co-financing;
10. Pooling international health financing helps richer countries to react to corruption or other forms of abuse of international health financing.

At least one of these arguments has been researched, specifically argument five relating to long-term predictability. Dodd and Lance found “increasing evidence of long-term commitments of aid for health in each of the seven agencies [reviewed]”, and that “[Global Health Partnerships] and their funders have been at the forefront of this trend, pioneering many of the new approaches”.¹¹⁴

However, we acknowledge that other attempts to manage health inter-dependence contain promising features as well. Each of these attempts to manage health inter-dependence has been well-researched. What seems to be missing is comparative research. How have PPPs performed in terms of enabling more ambitious health plans, when compared with SWApS or World Bank grants or loans? How have PPPs performed in terms of allowing meaningful civil society participation, when compared with SWApS or World Bank grants or loans? It may sound like a beauty contest or pageant, but such a comparative exercise may be what we need to extract the most promising elements of all existing attempts to manage health inter-dependence between countries.

Additional research

We recommend comparative research, in low-income countries that have been successful in obtaining Global Fund grants, in establishing a health sector SWAp, and in obtaining grants or loans from the World Bank, to assess how these mechanisms have performed so far, using a global universal health coverage perspective. We believe it would be useful to disaggregate between so-called ‘fragile states’ and others.

GENERAL CONCLUSION

In a recent report, taking stock of progress towards the health-related Millennium Development Goals (MDGs) and proposing principles for goal setting after 2015, Waage and colleagues conclude: “To escape this dichotomy [of disease-specific programs in tension with broader system-wide strengthening], we need to move the debate beyond the financial sustainability of individual countries’ health budgets. Sustainability has to be linked to global obligation and solidarity that allows rational planning with the assumption that funding will be predictable, reliable, and increasing every year.”¹¹⁵

The first section of this paper provides an overview of how this could happen. We argued that international health financing would ideally be linked to the national financing mechanisms chosen by countries among the options available to enable progress towards national universal health coverage: social health insurance or tax-based financing of the health sector. We also argued that, based on present estimates, one should expect international health co-financing to be required for several decades. Because long-term international co-financing is not foreseen in current research about universal health coverage, we defined *global* universal health coverage, as distinct from *national* universal health coverage.

The second and central section of this paper reviews the arguments for concerted global health action from the perspective of countries providing it, assuming they are self-interested. Even under these narrow assumptions, there seems to be a case for moving in the direction suggested by Waage and colleagues—which assumes acceptance of health inter-dependence between countries and a willingness to manage it.

The third section of this paper, however, suggests that such an intention is easier to express than to realize. In the absence of a world government, all countries try to preserve their autonomy. Countries providing international health co-financing will always want to make sure that their contributions finance what serves the interests of their inhabitants; countries receiving international health co-financing will want to provide the health goods their inhabitants want. To address this inevitable challenge, a governance mechanism will be needed that strikes the balance between the interests of all countries, in a manageable way. A combination of the most promising elements of recent attempts to manage health inter-dependence between countries might be the way forward.

We identified several areas for additional research. In broad lines, they can be separated in two groups: the first would contain additional research into the expected impact of global universal health coverage, and to which extent it would benefit the countries providing the required assistance; the second would contain additional research into the essential features of global universal health coverage. Although health systems research could perhaps provide beginnings of answers to some of these questions, our overview suggest that many scientists from different disciplines will have to come on board, to give more meaning to the promising idea that health is indeed a global affair.

REFERENCES

- 1 Carrin G, James C, Evans D (2005) Achieving universal health coverage: developing the health financing system. WHO, Technical Briefs of Policy-Makers, Number 1. Available from: http://www.who.int/health_financing/documents/pb_e_05_1-universal_cov.pdf
- 2 Twahirwa A (2008) Sharing the burden of sickness: mutual health insurance in Rwanda. *Bulletin of the World Health Organization*, 86(11): 823-824
- 3 Samb B, Evans T, Dybul M, Atun R, Moatti JP, Nishtar S et al. (2009) An assessment of interactions between global health initiatives and country health systems. *The Lancet*, 373(9681): 2137–2169
- 4 Kalk A, Groos N, Karas JC, Girrbaach E (2010) Health systems strengthening through insurance subsidies: the GFATM experience in Rwanda. *Tropical Medicine and International Health*, 15(1): 94–97
- 5 Schieber G, Baeza C, Kress D, Maier M (2006) Financing Health Systems in the 21st Century. In: Jamison DT, Breman JG, Measham AR, Alleyne G, Claeson M, Evans DB, Jha P, Mills A, Musgrove P (eds.) *Disease Control Priorities in Developing Countries* (2nd Edition). New York: Oxford University Press: 225-242
- 6 Ooms G, Derderian K, Melody D (2006) Do We Need a World Health Insurance to Realise the Right to Health? *PLoS Medicine*, 3(12): e530
- 7 Van Damme, W (2007) World Social Health Insurance: Strengthening Health Systems in Low-Income Countries. *PLoS Medicine*, 4(3): e137
- 8 Ooms G, Hammonds R (2008) Correcting globalisation in health: Transnational entitlements versus the ethical imperative of reducing aid-dependency. *Public Health Ethics*, 1(2): p. 154–170
- 9 International Conference on Social Health Insurance in Developing Countries (2006) Berlin Recommendations for Action. Available from: <http://www.socialhealthprotection.org/pdf/Berlin%20recommendation.pdf>
- 10 Carrin G, Evans D, Xu K (2007) Designing health financing policy towards universal coverage. *Bulletin of the World Health Organization*, 85(9): 652
- 11 Schieber G, Gottret P, Fleisher L, Leive A (2007) Financing Global Health: Mission Unaccomplished. *Health Affairs*, 26(4): p. 921-934
- 12 Organization of African Unity (2001) Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Available from: http://www.un.org/ga/aids/pdf/abuja_declaration.pdf
- 13 Global Health Watch (2006) A Health Systems Development Agenda for Developing Countries: Time to be clear and visionary. London: Global Health Watch. Available from: http://www.ghwatch.org/sites/www.ghwatch.org/files/adv_hsda.pdf
- 14 Grindle MS (1999) In Quest of the Political: The Political Economy of Development Policy Making. CID Working Paper No. 17. Available from: http://www.hks.harvard.edu/var/ezp_site/storage/fckeditor/file/pdfs/centers-programs/centers/cid/publications/faculty/wp/017.pdf
- 15 Martin, LL (1999) The Political Economy of International Cooperation. In: Kaul I, Grunberg I, Stern MA (eds.) *Global Public Goods: International Cooperation in the 21st Century*. New York, Oxford: Oxford University Press: 51-64.
- 16 Commission on Macroeconomics and Health (2001) *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: WHO. Available from: <http://whqlibdoc.who.int/publications/2001/9241544550x.pdf>
- 17 Farag M, Nandakumar AK, Wallack S, Gaumer G, Hodgkin D (2009) Does Funding From Donors Displace Government Spending For Health In Developing Countries? *Health Affairs*, 28(4): 1045-1055
- 18 Lu C, Schneider MT, Gubbins P, Leach-Kemon K, Jamison D, Murray CJL(2010) Public financing of health in developing countries: a cross-national systematic analysis. *The Lancet*, 375(9723): 1375–1387
- 19 Ooms G, Decoster K, Miti K, Rens S, Van Leemput L, Vermeiren P, Van Damme W (2010) Crowding out: are relations between international health aid and government health funding too complex to be captured in averages only? *Lancet*, 375(9723): 1403-1405
- 20 Foster Mick (2005) Fiscal space and sustainability: towards a solution for the health sector. In; High-Level Forum for the Health MDGs, Selected papers 2003-2005. WHO and World Bank, pp 67-88. Available from: http://www.who.int/hdp/publications/hlf_volume_en.pdf
- 21 Committee on Economic, Social and Cultural Rights (2000) General Comment No.14 on the right to the highest attainable standard of health. Available from: [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En)
- 22 Deacon B (2007) *Global Social Policy & Governance*. Los Angeles, London, New Delhi, Singapore: Sage.

-
- 23 Dybul, M (2010) Mothers Have Delivered for Us—Now Let’s Deliver for Them. The Huffington Post, May 2. Available from: http://www.huffingtonpost.com/amb-mark-dybul/mothers-day-mothers-have_b_557219.html
- 24 Frenk J, Quick JD, Pablos-Mendez A (2010) Are the Millennium Development Goals for Health on a Collision Course? The Huffington Post, September 12. Available from: http://www.huffingtonpost.com/julio-frenk-md-mph-phd/are-the-millennium-develo_b_719904.html
- 25 Sachs J (2010) Funding a Global Health Fund. The Guardian, March 25. Available from: <http://www.guardian.co.uk/commentisfree/2010/mar/25/global-health-fund-funding-tb-aids>
- 26 Morris K (2010) Profile: Tedros Adhanom Ghebreyesus—a Global Fund for the health MDGs. The Lancet, 375(9724): 1429
- 27 Van Ginneken W (2003) Extending social security: Policies for developing countries. International Labour Review, 142(3): 277-294
- 28 Milanovic B (2006) Global Income Inequality: What it is and why it matters. World Bank Policy Research Working Paper 3865. Available from: <http://go.worldbank.org/YVPXW24U40>
- 29 Faux J (2000) Toward a Global Social Contract: The politics of the global economy. Speech presented at the Latin American Faculty of Social Sciences 25th Anniversary Conference on October 25th, 2000. Available from: http://www.epi.org/publications/entry/webfeatures_viewpoints_mexico_grand_bargain/
- 30 Keohane RO (1984) After Hegemony: Cooperation and Discord in the World Political Economy. Princeton: Princeton University Press.
- 31 Oye KA (1986) Cooperation under Anarchy. Princeton: Princeton University Press.
- 32 Institute of Medicine, Board on International Health (1997) America’s vital interest in global health: protecting our people, enhancing our economy, and advancing our international interests. Washington DC: National Academy Press
- 33 Amorim C, Douste-Blazy P, Wirayuda H, Støre JD, Gadio CT, Dlamini-Zuma N, Pibulsonggram N (2007) Oslo Ministerial Declaration—global health: a pressing foreign policy issue of our time. The Lancet, 369(9570): 1373-1378
- 34 HM Government (2008) Health is global: a UK Government strategy 2008–13. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088753.pdf
- 35 Jones KA (2010) New Complexities and Approaches to Global Health Diplomacy: View from the U.S. Department of State. PLoS Medicine, 7(5):e1000276
- 36 Prentice T, Reinders LT (2007) A Safer Future: Global Public Health Security. World Health Report 2007. Geneva: World Health Organization. Available from: http://www.who.int/whr/2007/whr07_en.pdf
- 37 Fidler D (2005) Health as Foreign Policy: Between Principle and Power. Whitehead Journal of Diplomacy and International Relations, 6(2): 179-194
- 38 Wilson K (2009) Securing the Public Health Realm: Re-envisioning Canada’s Role in the New Century. Policy Options, 10(7): 104-108
- 39 Labonté R (2008) Global health in public policy: finding the right frame? Critical Public Health, 18(4): 467-482
- 40 Horton R (2001) Public health: a neglected counterterrorist measure. The Lancet, 358(9288): 1112-1123
- 41 High-level Panel on Threats, Challenges and Change (2004) A more secure world: Our shared responsibility. Report of the Secretary General’s High-level Panel on Threats, Challenges and Change. New York: United Nations. Available from: <http://www.un.org/secureworld/report2.pdf>
- 42 McInnes C, Lee K (2006) Health, security and foreign policy. Review of International Studies, 32(1): 5-23
- 43 Brainard L (2007) A Unified Framework for U.S. Foreign Assistance. In: Brainard L (ed.), Security by other means: foreign assistance, global poverty and American leadership. Washington DC: Brookings Institution.
- 44 Morrison JS (2007) What Role for U.S. Assistance in the Fight against Global HIV/AIDS? In: Brainard L (ed.), Security by other means: foreign assistance, global poverty and American leadership. Washington DC: Brookings Institution.
- 45 Dietrich JW (2007) The Politics of PEPFAR: The President’s Emergency Plan for AIDS Relief. Ethics & International Affairs, 21(3): 277-292
- 46 Barnett T (2009) HIV/AIDS and State Fragility. ASCI synthesis paper. Available from: <http://asci.researchhub.ssrc.org/working-papers/ASCI%20Synthesis%20Paper%20State%20Fragility.pdf>
- 47 de Waal A (2010) Reframing governance, security and conflict in the light of HIV/AIDS: A synthesis of findings from the AIDS, security and conflict initiative. Social Science & Medicine, 70(1): 114-120
- 48 Rushton S, McInnes C (2006) The UK, health and peace-building: the mysterious disappearance of Health as a Bridge for Peace. Medicine, Conflict and Survival, 22(2): 94-109
- 49 Freedman L (2005) Achieving the MDGs: Health Systems as Core Social Institutions. Development, 48: 19-24

-
- 50 Ranson MK, Poletti T, Bornemisza O, Sondorp E (2007) Promoting Health Equity in Conflict-Affected Fragile States. Report prepared for the Health Systems Knowledge Network of the WHO Commission on Social Determinants of Health. London: London School of Hygiene & Tropical Medicine. Available from: http://www.who.int/social_determinants/resources/csdh_media/promoting_equity_conflict_2007_en.pdf
- 51 Grove NJ, Zwi AB (2008) Beyond the log frame: a new tool for examining health and peacebuilding initiatives. *Development in Practice*, 18(1): 66-81
- 52 Humpreys M, Richards P (2005) Prospects and Opportunities for Achieving the MDGs in Post-conflict Countries: A Case Study of Sierra Leone and Liberia. Available from: <http://www.columbia.edu/~mh2245/papers1/HR.pdf>
- 53 Ohiorhenuan JFE, Stewart F (2008) Post-Conflict Economic Recovery: Enabling Local Ingenuity. New York: United Nations Development Programme. Available from: http://www.undp.org/cpr/content/economic_recovery/PCERreport.pdf
- 54 Kruk ME, Freedman L, Anglin GA, Waldman RJ (2010) Rebuilding health systems to improve health and promote statebuilding in post-conflict countries: A theoretical framework and research agenda? *Social Science & Medicine*, 70(1): 89-97
- 55 Armitage RL, Nye JS (2007) Center for Strategic & International Studies Commission on Smart Power: A smarter more secure America. Washington DC: CSIS. Available from: http://csis.org/files/media/csis/pubs/071106_csissmartpowerreport.pdf
- 56 Feldbaum H, Michaud J (2010) Health Diplomacy and the Enduring Relevance of Foreign Policy Interests. *PLoS Medicine*, 7(4): e1000226
- 57 Fidler D, Drager N (2006) Health and foreign policy. *Bulletin of the World Health Organization*, 84(9): 687
- 58 Fidler D (2007) Architecture amidst Anarchy: Global Health's Quest for Governance. *Global Health Governance*, 1(1): 1-17
- 59 Kickbusch I (2005) Tackling the political determinants of global health. *BMJ*, 331(7511): 146-247
- 60 Kickbusch I, Silberschmidt G, Buss P (2007) Global health diplomacy: the need for new perspectives, strategic approaches and skills in global health. *Bulletin of the World Health Organization*, 85(3): 230-232
- 61 Kickbusch I, Novotny TE, Drager N, Silberschmidt G, Alcazar S (2007) Global health diplomacy: training across disciplines. *Bulletin of the World Health Organization*, 85(12): 971-973
- 62 Hatton TJ, Williamson JG (2003) Demographic and Economic Pressure on Emigration out of Africa. *Scandinavian Journal of Economics*, 105(3): 465-486
- 63 Gushulak B (2007) Healthier on arrival? Further insight into the "healthy immigrant effect". *Canadian Medical Association Journal*, 176(10): 1439-1440
- 64 Mladovsky P (2007) Migration and health in the EU. Research Note produced for the European Commission. Available from: <http://mighealth.net/eu/images/3/3b/Mlad.pdf>
- 65 Hatton TJ, Williamson JG (2003) What Fundamentals Drive World Migration? United Nations University, World Institute for Development Economics Research, Discussion Paper No. 2003/23. Available from: <http://www.wider.unu.edu/stc/repec/pdfs/rp2003/dp2003-23.pdf>
- 66 Jamison DT (1993) *World Development Report 1993: Investing in Health*. Oxford: Oxford University Press
- 67 Mills A, Bennett S, Gilson L (2008) Health, economic development, and household poverty: the role of the health sector. In Sara Bennett, Lucy Gilson, and Anne Mills (eds.) *Health, Economic Development, and Household Poverty: From Understanding to Action*. New York: Routledge
- 68 Rivera B, Currais L (1999) Economic growth and health: direct impact or reverse causation? *Applied Economics Letters*, 6(11): 761-764
- 69 Acemoglu D, Robinson J, Johnson S (2003) Disease and Development in Historical Perspective. *Journal of the European Economic Association*, 1(2/3): 397-405
- 70 Acemoglu D, Johnson S (2007) Disease and Development: The Effect of Life Expectancy on Economic Growth. *Journal of Political Economy*, 115(6): 925-985
- 71 Bloom D, Canning D (2008) Population Health and Economic Growth. Working Paper no.24 for the Commission on Growth and Development. Washington DC: The World Bank. Available from: <http://www.growthcommission.org/storage/cgdev/documents/gcwp024web.pdf>
- 72 Cichon M, Hagemeyer K (2007) Changing the development policy paradigm: Investing in a social security floor for all. *International Social Security Review*, 60(2-3): 169-196
- 73 McCoy D, Chand S, Sridhar D (2009) Global health funding: how much, where it comes from and where it goes. *Health Policy and Planning*, 24(6): 407-417
- 74 Attaran A, Gillespie-White L (2001) Do Patents for Antiretroviral Drugs Constrain Access to AIDS Treatment in Africa? *JAMA*, 286(15):1886-1892
- 75 Watson, R (2010) Council of Europe launches investigation into H1N1 pandemic. *BMJ*, 340:c641
- 76 Corvalán C, Hales S, McMichael A (2005) *Ecosystems and Human Well-being*. Geneva: WHO. Available from: <http://www.who.int/globalchange/ecosystems/ecosys.pdf>

-
- 77 McMichael AJ, Butler CD (2007) Emerging health issues: the widening challenge for population health promotion. *Health Promotion International*, 21(S1): 15-24
- 78 Yücel G, Barlas Y (2010) Dynamics of the North–South welfare gap and global sustainability. *Technological Forecasting & Social Change* 77(4): 594–614
- 79 Lee R (2003) The Demographic Transition: Three Centuries of Fundamental Change. *The Journal of Economic Perspectives*, 17(4): 167-190
- 80 Cleland J (2001) The Effects of Improved Survival on Fertility: A Reassessment. *Population and Development Review*, 27(Supplement: Global Fertility Transition): 60-92
- 81 Mason KO (1997) Explaining Fertility Transitions. *Demography*, 34(4): 443-454
- 82 Haines A, Smith KR, Anderson D, Epstein PR, McMichael AJ, Roberts I, Wilkinson P, Woodcock J, Woods J (2007) Policies for accelerating access to clean energy, improving health, advancing development, and mitigating climate change. *The Lancet*, 370(9594): 1264–1281
- 83 Golub A, Markandya A, Marcellino D (2009) Does the Kyoto Protocol cost too much and create unbreakable barriers for economic growth? In: Golub A, Markandya A (eds.) *Environment-Improving Technological Innovations Under Uncertainty*. New York: Routledge
- 84 Mahhubani K (2002) *Can Asians Think?* Second edition. Singapore: Times Books International
- 85 Sen A (1999) *Development as freedom*. Oxford: Oxford University Press
- 86 Commission on Human Security (2003) *Human Security Now*. Washington DC: Communications Development Incorporated. Available from: <http://www.humansecurity-chs.org/finalreport/English/FinalReport.pdf>
- 87 Haq M, Kaul I, Menon S, Jahan S (1994) *Human Development Report 1994: New dimensions of human security*. New York: UNDP
- 88 Takemi K, Jimba M, Ishii S, Katsuma Y, Nakamura Y (2008) Human security approach for global health. *The Lancet*, 372(9632): 13-14
- 89 Frenk J (2009) Strengthening health systems to promote security. *The Lancet*, 373(9682): 2181-2182
- 90 Mack A, Nielsen Z (2005) *Human Security Report 2005: War and Peace in the 21st Century*. New York, Oxford: Oxford University Press
- 91 International Task Force on Global Public Goods (2006) *Meeting Global Challenges: International Cooperation in the National Interest*. Report of the International Task Force on Global Public Goods. Washington DC: Communications Development Incorporated
- 92 Dunn JR, Ross NA (2009) 'Public goods', metropolitan inequality and population health in comparative perspective: policy and theory. In: Babones SJ (ed.) *Social Inequality and Public Health*. Bristol: The Policy Press
- 93 Long D, Woolley F (2009) Global Public Goods: Critique of a UN Discourse. *Global Governance*, 15(1): 107-122
- 94 Chen LC, Evans TG, Cash RA (1999) Health as a Global Public Good. In: Kaul I, Grunberg I, Stern MA (eds.) *Global Public Goods: International Cooperation in the 21st Century*. New York, Oxford: Oxford University Press
- 95 Arhin-Tenkoran Dyna, Conceição P (2003) Beyond Communicable Disease Control: Health in the Age of Globalization. In: Kaul I, Conceição P, Le Goulven K, Mendoza RU (eds.) *Providing Global Public Goods: Managing Globalization*. New York, Oxford: Oxford University Press
- 96 Collier P (2008) International Political Economy: Some African Applications. *Journal of African Economies*, 17(AERC Supplement 1): i110-i139
- 97 Baum F (2007) Reviving the spirit of Alma Ata in the twenty-first century: An Introduction to the Alma Ata Declaration. *Social Medicine*, 2(1): p 34-41
- 98 Maciocco G (2008) From Alma Ata to the Global Fund: The History of International Health Policy. *Social Medicine*, 3(1): 36-48
- 99 International Conference on Primary Health Care (1978) Declaration of Alma-Ata. Available from: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf
- 100 Walsh, JA, Warren KS (1979) Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries. *New England Journal of Medicine*, 301(18): 967-974
- 101 Rawls J (1999) *A Theory of Justice*, Revised Edition. Oxford: Oxford University Press
- 102 Rawls J (1999) The Law of Peoples, with 'The Idea of Public Reasoning' Revisited. Cambridge: Harvard University Press: 113-120
- 103 LaFond A (1995) *Sustaining Primary Health Care*. London: Earthscan
- 104 Hutton G, Tanner M (2004) The sector-wide approach: a blessing for public health? *Bulletin of the World Health Organization*, 82 (12): 893-894

-
- 105 Hill PS (2002) The rhetoric of sector-wide approaches for health development. *Social Science & Medicine*, 54: 1725-1737
- 106 Buse K, Harmer AM (2007) Seven habits of highly effective global public-private health partnerships: Practice and potential. *Social Science & Medicine*, 64(2):259-271
- 107 Brugha R, Donoghue M, Starling M, Ndubani P, Ssengooba F, Fernandes B, Walt G (2004) The Global Fund: managing great expectations. *The Lancet*, 364(9428): 95-100
- 108 Abassi K (1999) The World Bank and world health: Changing sides. *BMJ*, 318(7187): 865-869
- 109 World Bank (2010) World Bank website: "Home" → "About Us" → "Boards of Governors". Available from: <http://go.worldbank.org/YM7PNV3110>
- 110 Murray CJL, Frenk J, Evans T (2007) The Global Campaign for the Health MDGs: challenges, opportunities, and the imperative of shared learning. *Lancet*, 370(9592): 1018-1020
- 111 Labonté R, Marriott A (2010) IHP+: little progress in accountability or just little progress? *The Lancet*, 375(9725): 1505-1507
- 112 Hill PS (2010) Understanding global health governance as a complex adaptive system. *Global Public Health*, 2010 Apr 28:1-13 (early online publication)
- 113 Ooms G (2009) From the Global AIDS Response towards Global Health? Discussion paper for the Hélène De Beir Foundation and International Civil Society Support. Available from: [http://www.internationalhealthpartnership.net/pdf/IHP%20Update%202013/Taskforce/taskforce/090101_Ooms_Global_Health_Discussion_Paper%20\(2\).pdf](http://www.internationalhealthpartnership.net/pdf/IHP%20Update%202013/Taskforce/taskforce/090101_Ooms_Global_Health_Discussion_Paper%20(2).pdf)
- 114 Dodd R, Lane C (2010) Improving the long-term sustainability of health aid: are Global Health Partnerships leading the way? *Health Policy and Planning Advance Access published May 14, 2010*
- 115 Waage J, Banerji R, Campbell O, Chirwa E, Collender G, Dieltiens V, Dorward A, Godfrey-Faussett P, Hanvoravongchai P, Kingdon G, Little A, Mills A, Mulholland K, Mwinga A, North A, Patcharanarumol W, Poulton AC, Tangcharoensathien V, Unterhalter E (2010) The Millennium Development Goals: a cross-sectoral analysis and principles for goal setting after 2015. *The Lancet*, 376(9745): 991-1023

ANNEX 1

Assumptions:

- The minimum cost of essential health goods is \$40 per person per year;
- The maximum domestic contribution is the equivalent of 3% of GDP.

Countries with GDP < US\$1,333 per person: population, domestic and international contribution to universal health coverage at US\$40 per person per year					
Country	GDP per capita	Population	Domestic contribution per person	International contribution per person	International contribution total
1 Burundi	120.28	7.64	3.61	36.39	278.07
2 Congo, Democratic Republic of	148.75	59.28	4.46	35.54	2,106.49
3 Liberia	170.94	3.58	5.13	34.87	124.81
4 Guinea-Bissau	192.92	1.65	5.79	34.21	56.31
5 Ethiopia	202.05	75.07	6.06	33.94	2,547.80
6 Malawi	239.69	13.12	7.19	32.81	430.52
7 Sierra Leone	254.29	5.59	7.63	32.37	181.02
8 Myanmar	256.66	56.51	7.70	32.30	1,825.12
9 Eritrea	258.13	4.69	7.74	32.26	151.55
10 Niger	281.80	12.95	8.45	31.55	408.49
11 Madagascar	287.87	19.16	8.64	31.36	600.90
12 Afghanistan, Rep. of.	289.31	26.70	8.68	31.32	836.11
13 Guinea	300.97	9.65	9.03	30.97	298.71
14 Rwanda	307.88	9.20	9.24	30.76	283.02
15 Zimbabwe	318.99	11.73	9.57	30.43	357.01
16 Timor-Leste, Dem. Rep. of	321.93	1.02	9.66	30.34	30.80
17 Gambia, The	328.29	1.55	9.85	30.15	46.67
18 Nepal	333.20	27.11	10.00	30.00	813.47
19 Uganda	333.52	29.85	10.01	29.99	895.45
20 Central African Republic	352.28	4.19	10.57	29.43	123.20
21 Togo	352.36	6.30	10.57	29.43	185.43
22 Mozambique	361.80	19.94	10.85	29.15	581.23
23 Tanzania	375.68	38.20	11.27	28.73	1,097.47
24 Bangladesh	418.10	155.96	12.54	27.46	4,282.08
25 Burkina Faso	430.51	13.42	12.92	27.08	363.42
26 Tajikistan	440.58	6.38	13.22	26.78	170.90
27 Mali	480.07	12.77	14.40	25.60	326.78
28 Cambodia	512.87	14.16	15.39	24.61	348.61
29 Kyrgyz Republic	545.93	5.20	16.38	23.62	122.74
30 Haiti	570.44	8.48	17.11	22.89	194.04
31 Lao People's Democratic Republic	593.57	6.03	17.81	22.19	133.74
32 Ghana	594.19	21.42	17.83	22.17	475.04
33 Benin	622.58	7.61	18.68	21.32	162.31
34 Lesotho	641.50	2.36	19.25	20.76	49.06
35 Uzbekistan	642.80	26.49	19.28	20.72	548.73
36 Comoros	645.11	0.63	19.35	20.65	12.92
37 Kenya	661.40	34.05	19.84	20.16	686.30
38 Chad	680.86	9.26	20.43	19.57	181.28
39 Vietnam	724.05	84.16	21.72	18.28	1,538.25
40 India	759.90	1,152.05	22.80	17.20	19,818.84
41 Senegal	784.62	11.94	23.54	16.46	196.52
42 São Tomé and Príncipe	808.41	0.16	24.25	15.75	2.44
43 Pakistan	820.55	155.37	24.62	15.38	2,390.14
44 Yemen, Republic of	881.65	21.62	26.45	13.55	292.99
45 Côte d'Ivoire	883.27	19.57	26.65	13.35	261.30
46 Nicaragua	890.36	5.91	26.71	13.29	78.57
47 Zambia	917.42	11.87	27.52	12.48	148.15
48 Solomon Islands	923.50	0.50	27.70	12.30	6.09
49 Mauritania	933.42	2.89	28.00	12.00	34.70
50 Papua New Guinea	947.37	5.92	28.42	11.58	68.51
51 Moldova	949.46	3.59	28.48	11.52	41.34
52 Cameroon	979.05	18.34	29.37	10.63	194.94
53 Sudan	1,005.06	36.22	30.15	9.85	356.69
54 Djibouti	1,029.54	0.75	30.89	9.11	6.81
55 Nigeria	1,038.76	140.00	31.16	8.84	1,237.25
56 Kiribati	1,118.48	0.10	33.55	6.45	0.62
57 Bolivia	1,197.24	9.63	35.92	4.08	39.31
58 Guyana	1,200.76	0.76	36.02	3.98	3.02
59 Mongolia	1,223.77	2.58	36.71	3.29	8.48
		2,452.77			49,042.34

Source: International Monetary Fund, World Economic Outlook Database, October 2009

ANNEX 2

This table is a selective combination of purchase price reports of the Global Fund, illustrating that most of the antiretroviral medicines are generics purchased in India, even in countries where some components are allegedly protected by patents.

Purchase Price Report

Region	Country	Manufacturer name	Manufacturing site	Display name
Middle East and North Africa	Chad	Cipla Ltd	Goa, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
Middle East and North Africa	Mali	Cipla Ltd	Goa, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
Middle East and North Africa	Mauritania	Aurobindo Pharma Ltd	Hyderabad Qutubullahpur Mandall, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
Middle East and North Africa	Niger	Cipla Ltd	Goa, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
Middle East and North Africa	Somalia	Strides Arcolab Ltd	Bangalore, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
Middle East and North Africa	Sudan	Ranbaxy Laboratories Ltd	Pahonta Sahib, Himachal Pradesh, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
West and Central Africa	Burkina Faso	Ranbaxy Laboratories Ltd	Pahonta Sahib, Himachal Pradesh, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
West and Central Africa	Cameroon	Hetero Drugs Limited	Hyderabad, Andhra Pradesh, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle
West and Central Africa	Central African Republic	Matrix Laboratories Ltd	Nashik, Maharashtra, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
West and Central Africa	Gambia	Cipla Ltd	Goa, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
West and Central Africa	Guinea	Cipla Ltd	Goa, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
West and Central Africa	Nigeria	Cipla Ltd	Goa, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
West and Central Africa	Sierra Leone	Cipla Ltd	Patalganga, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
East Africa and Indian Ocean	Tanzania (United Republic)	Cipla Ltd	Goa, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
Southern Africa	Lesotho	Cipla Ltd	Goa, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle (HDPE)
Southern Africa	Malawi	Hetero Drugs Limited	Hyderabad, Andhra Pradesh, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle
Southern Africa	Swaziland	Hetero Drugs Limited	Hyderabad, Andhra Pradesh, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle
Southern Africa	Zambia	Cipla Ltd	Goa, India	Lamivudine / Nevirapine / Stavudine 60 mg / 100 mg / 12 mg 60 Tablets Bottle (HDPE)
Southern Africa	Zimbabwe	Hetero Drugs Limited	Hyderabad, Andhra Pradesh, India	Lamivudine / Nevirapine / Stavudine 150 mg / 200 mg / 30 mg 60 Tablets Bottle

ANNEX 3

	Member State	Infant mortality rate (probability of dying by age 1 per 1000 live births)								
		Male			Female			Both sexes		
		1990	2000	2008	1990	2000	2008	1990	2000	2008
1	Afghanistan	175	172	172	160	158	158	168	165	165
2	Angola	161	148	136	147	134	124	154	141	130
3	Democratic Republic of the Congo	133	133	133	119	119	119	126	126	126
4	Chad	127	130	132	112	114	116	120	122	124
5	Sierra Leone	178	165	135	148	137	112	163	151	123
6	Somalia	121	121	121	117	117	117	119	119	119
7	Guinea-Bissau	157	142	129	127	115	104	142	129	117
8	Central African Republic	120	123	118	112	115	111	116	119	115
9	Burundi	125	118	112	102	96	92	113	107	102
10	Mali	147	127	109	130	112	96	139	120	102
11	Liberia	154	125	106	138	112	95	146	118	100
12	Nigeria	128	114	102	112	100	89	120	107	96
13	Burkina Faso	114	106	95	106	98	89	110	102	92
14	Zambia	117	116	102	93	93	82	105	104	92
15	Equatorial Guinea	128	108	95	111	95	84	120	102	90
16	Guinea	152	124	100	121	98	80	137	111	90
17	Mozambique	171	128	93	161	120	88	166	124	90
18	Uganda	128	110	95	99	85	74	114	98	84
19	Cameroon	99	99	89	84	84	75	92	91	82
20	Côte d'Ivoire	115	106	89	93	85	72	104	96	81
21	Kenya	75	90	89	60	72	71	68	81	81
22	Congo	69	76	82	64	71	77	67	74	80
23	Gambia	111	100	85	96	87	74	104	93	80
24	Niger	148	110	81	140	104	76	144	107	79
25	Benin	117	94	81	104	84	72	111	89	76
26	Djibouti	108	95	86	82	72	66	95	84	76
27	Myanmar	96	86	85	74	67	66	85	77	76
28	Comoros	99	90	83	80	73	67	90	81	75
29	Mauritania	86	82	80	75	71	69	81	77	75
30	Timor-Leste	155	112	84	120	87	65	138	100	75
31	Pakistan	105	89	75	96	81	69	101	85	72
32	Rwanda	114	121	77	98	104	66	106	112	72
33	Sudan	75	70	67	81	76	72	78	73	70
34	Cambodia	94	88	76	76	71	62	85	80	69
35	Ethiopia	140	103	78	108	79	60	124	91	69
36	Madagascar	110	89	74	93	76	62	101	83	68
37	United Republic of Tanzania	100	89	69	94	85	65	97	87	67
38	Malawi	139	105	68	126	95	61	133	100	65
39	Sao Tome and Principe	69	68	67	61	60	60	65	64	64
40	Togo	103	88	74	75	64	54	89	76	64
41	Lesotho	85	88	67	75	77	59	80	83	63
42	Zimbabwe	53	64	64	49	59	59	51	62	62
43	Swaziland	65	87	62	59	79	56	62	83	59
44	Gabon	80	76	68	53	51	45	67	64	57
45	Senegal	80	73	63	64	58	50	72	66	57
46	Bhutan	99	73	58	84	62	49	91	68	54
47	Haiti	112	84	58	96	72	50	105	78	54
48	Tajikistan	106	87	63	76	63	45	91	75	54
49	Papua New Guinea	69	61	56	64	53	49	67	57	53
50	Yemen	96	76	56	83	66	49	90	71	53
51	India	82	67	52	84	69	53	83	68	52
52	Ghana	79	74	54	71	67	48	75	71	51
	Source: WHO									

ANNEX 4

Country Name	External resources in 2007	
Niger	74.91	
Micronesia, Fed. Sts.	72.41	
Marshall Islands	66.05	
Malawi	59.93	
Mozambique	57.78	
Liberia	57.69	
Rwanda	52.34	
Tanzania	49.91	
Congo, Dem. Rep.	47.81	
Eritrea	46.48	
Ethiopia	43.87	
Solomon Islands	43.61	
Burundi	40.03	
Palau	39.90	
Haiti	37.69	
Guinea-Bissau	35.01	
Timor-Leste	34.99	
Zambia	33.12	
Uganda	31.64	
Sierra Leone	31.29	
Kiribati	30.49	
Papua New Guinea	29.68	
Burkina Faso	28.31	
Central African Republic	25.86	
Iraq	25.30	
Guyana	24.99	
Gambia, The	24.32	
Kenya	24.11	
Sao Tome and Principe	21.73	
Benin	21.26	
Comoros	20.92	
Tonga	20.25	
Afghanistan	20.18	

“It may be concluded that in the first years of the twenty-first century, the world is stumbling towards articulating a global social policy of global redistribution, global social regulation, and global social rights, and creating the instruments necessary for the realization of such policies in practice.”

Bob Deacon, Global Social Policy & Governance, 2007

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