

Contents

<i>List of Tables</i>	vii
<i>List of Figures</i>	viii
<i>Foreword by Alan Whiteside</i>	ix
<i>List of Abbreviations</i>	xi
<i>Notes on Contributors</i>	xv

Part I Introduction

1 Introduction: The Social Determinants of Global Health: Confronting Inequities <i>Sandra J. MacLean and Sherri A. Brown</i>	3
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Part II Globalization, the State, and Global Health

2 The G8, Globalization, and the Need for a Global Health Ethic <i>Ted Schrecker</i>	21
3 The Accumulative Nature of the US Health Complex <i>Rodney Loepky</i>	39
4 Palliative Interventions: Canadian Foreign Policy, Security and Global Health Governance <i>Colleen O'Manique</i>	53
5 The Relationship between the AIDS Pandemic and State Fragility <i>Pieter Fourie</i>	67

Part III From International to Global Health Governance

6 Transnational Norm-Building in Global Health: The Important Role of Non-State Actors in Post-Westphalian Politics <i>Wolfgang Hein and Lars Kohlmorgen</i>	87
7 Global Public Health and Innovation in Governance: The Emergence of Public–Private Partnerships <i>Carmen Huckel Schneider</i>	105
8 Philanthropic Foundations and Global Health Partnership Formation: The Rockefeller Foundation and IAVI <i>Michael Moran</i>	118

- 9 Southern Actors in Global Public–Private Partnerships:
The Case of the Global Fund 130
Sonja Bartsch
- 10 ‘Making the Money Work’: Challenges towards
Coordination of HIV/AIDS Programmes in Africa 145
Siri Bjerkreim Hellevik

**Part IV The Governance of Global Health Research
and Product Access**

- 11 The Political Economy of Global Health Research 165
Sandra J. MacLean and David R. MacLean
- 12 Dealing with Public Health and Intellectual Property for
Pharmaceuticals at the World Trade Organization 183
Valbona Muzaka
- 13 Patents, Policies and Pricing: Access to Medicines for
Vulnerable Populations in a Global Economy 196
Shree Mulay, Eowynne Feeney and Daya R. Varma
- 14 The Partnership Prescription: Access to HIV/AIDS-related
Medicines and Public–Private Partnerships 210
Sherri A. Brown

Part V Conclusion

- 15 Conclusion: Towards Equitable Global Health Governance 227
Sherri A. Brown and Sandra J. MacLean

References 237

Index 273

Part I

Introduction

PROOF

1

Introduction: The Social Determinants of Global Health: Confronting Inequities

Sandra J. MacLean and Sherri A. Brown

Health, at a population level, is largely socially determined; consequently, rich countries and communities tend to have significantly better health outcomes than poor ones. In the current era, this observation is critical, given that globalization has been implicated in producing economic convergence within and between some countries, but appreciably greater socioeconomic gaps in others (Farmer, 2003; OECD, 2008). To grasp the nature of health and disease in the world today, therefore, entails understanding not only biological phenomena, but also who wins and who loses as a result of the recent changes in global political economy. Moreover, to be effective, global health governance must address the underlying structures of political economy that are primary sources of social inequalities and inequities and thus contributors to negative health outcomes (CSDH, 2008).

Over the past two to three decades, several health problems with worldwide implications have emerged to spawn an explosion of interest in 'global health'. The burgeoning literature on the subject has produced important and informative research on a set of issues. However, there are problems with the current situation in global health analysis. First, there are conceptual problems. The notion of global health is not often clearly defined; it is frequently used, for instance, in ways that do not distinguish it from the long-established concept of international health. Second, the weights given to the range of issues addressed are skewed; in particular, much of the attention is focused on infectious disease to the detriment of research on chronic disease as a global health issue. Third, while interdisciplinarity is a welcome feature of global health scholarship, emerging bridges between public health and international political economy (IPE) and international relations (IR) are still inadequately constructed¹; few public health scholars address health through a meaningful engagement with the causal issues of political economy, while many IPE and IR scholars focus mainly on health as a security issue, paying little attention to the compelling social determinants of

health literature. Finally, while the global health governance literature has been preoccupied with new governance forms, such as public private partnerships (PPPs), the majority of the analyses to date have been essentially descriptive accounts of the nature and form of an emerging governance architecture; there has been insufficient attention paid to the way that these novel arrangements conform to, much less challenge, structural inequalities in the global economy.

This collection, which comprises edited and updated versions of papers originally presented in September 2007 at the Sixth Pan-European Conference on International Relations in Turin, Italy, is an attempt to stimulate discussion and debate on these still undertheorized areas. It seeks to disaggregate the two overarching themes – (i) the impact on health of political economy changes associated with globalization, and (ii) emerging forms of global health governance – by identifying the major players responsible for framing, and thus controlling, the current global health paradigm; by exposing the nature and extent of inequalities that are emerging in areas of global health; and by analyzing the potentials and problems of current forms of global health governance. Because the problems of global health (and the potential solutions) are embedded in social dynamics, as much as or more than in biological determinants or technical innovation, there is a compelling need for interdisciplinary approaches in the analysis of global health, drawing especially, but not only, on IPE and IR. Consequently, the proposed volume includes contributions from scholars in the fields of Public and Population Health as well as IR IPE. Furthermore, as senior and junior scholars representing several countries/geographic areas and different analytical approaches, the contributors bring comprehensive and nuanced analyses of global health/global health governance, an area in which there is a growing, but still nascent and inchoate, literature.

Conceptualizing global health

The political economy of global health

The term ‘global health’ is not entirely new (there are occasional references to it in the literature at least as far back as the 1950s), but in the past two decades the use of the term has escalated noticeably (Brown et al., 2006). Given that most aspects of human life are now being re-evaluated within the context of globalization, it is not unexpected that the critical area of health would be scrutinized as a ‘global’ issue. But what exactly is *global* about global health?

Global phenomena may be defined as events and experiences having worldwide reach or impact, as in global warming affecting the entire world. Thus, by this definition, global health involves health issues that are experienced in all areas of the world and/or those that derive from phenomena that have global reach. However, this definition does not address causal

factors or provide any insights regarding what has changed to allow us to now regard global health as a new disciplinary focus. What, for instance, distinguishes global health from international health? In IR and IPE literatures, to reflect the transformational nature of globalization, global phenomena tend often to be defined by comparison with international events and processes. Some scholars view globalization as intensified international relations: greater interconnectedness occurring at an 'accelerated pace' (McGrew, 2006, p. 22). Interconnectedness implies that the events and practices in one area impact upon people and communities in other parts of the world. However, as this feature applies to both international and global orders, globalization is distinguished by the remarkable rapidity with which the impacts are felt around the world. Moreover, the interconnections are vertical as well as horizontal, and the local–global interface has become an important terrain of economic, political and social interaction. Also, according to Jan Aart Scholte (2000), an essential feature of globalization is deterritorialization, meaning that the increasing social interactions occurring around the world rely less than previously, and sometimes not at all, on geographical space and boundaries.

While globalization involves transformations of social and cultural as well as economic and political relations, political economy (defined here as the inseparable integration of politics and economy) is the essential driver of the changes (see, for example, Cox, 2000). As Ronen Palan (2000) observes, all perspectives of political economy have been interested traditionally in the themes of 'state, firm, capital, power [and] labour'. Over the past two to three decades, a preoccupation of many, especially critical, scholars in the field has been to map and explain the changes in relations among these sets of actors under the dominance of neoliberalism. Core features of the transition from predominately international to increasingly global relations in the neoliberal order are: the transnationalization of production and finance (Scholte, 2000); the role of technology as both product and driver of changes in production and distribution; and the loss of bargaining power of labour vis-à-vis the state (Tabb, 2004, pp. 22–3). The role of the state in this transformation is both critical and complicated. While transnational capital is identified as the leading force in globalization (Gill, 2008), states are viewed as actors that have been complicit in support of these changes as well as respondents to, and sometimes victims of, the transformations (Sørensen, 2002). Another important feature of the changing political economy not identified in Palan's list is the increasing importance of civil society organizations as central members in the contemporary nexus of relevant governance actors (Cox, 1999; O'Brien et al., 2000). As with the state, civil society actors can assist or resist globalization, although resistance activities have been the most frequently documented (e.g., see Broad, 2002; Gill, 2008).

The concept of global health, then, as distinct from international health, is consequential only within the context of these global changes in political

economy. The term 'international health' has been widely used for several decades to refer to interventions by health organizations such as the World Health Organization (WHO) and personnel (usually health professionals from the North) in other countries (usually in the South) to produce health improvements (MacLean, 2007). The main foci of the international health agenda have been the control and reduction of infectious disease, maternal and child health, and, to a somewhat lesser extent, the health of workers and health-related trade. All of these issues continue to be important considerations within a global health paradigm, but it is the impact of globalization processes upon these and other health issues that makes the concept of *global health* meaningful. In other words, global health can be understood as health conditions and outcomes that are determined by changes in relations among state, business, labour and civil society resulting from increased interdependence and deterritorialization of social relations. This conceptualization of global health provides a theoretical framework for exploring the cause and nature of the changes. To date, other definitions of global health, while useful, have been mainly descriptive, as, for instance, is the following from Lee and Collin (2005, p. 3), who assert that a global health issue is one '... where the determinants circumvent, undermine or are oblivious to the territorial boundaries of states and, thus, beyond the capacity of individual countries to address through domestic institutions'.

The transition from international to global health

After the Second World War, it was thought that the international spread of infectious disease had been brought under control within a health governance framework led by the WHO (MacLean, 2007). However, any complacency that accompanied this perceived success began to dissolve in the 1980s following outbreaks of lethal, highly contagious, infectious diseases such as Ebola and the rapid worldwide spread of HIV/AIDS. The range and speed of transmission of HIV, in particular, but also the resurgence of old diseases such as drug-resistant malaria and tuberculosis, provided clear evidence of the high degree of interdependence in the contemporary world, and also demonstrated that, with advances in transportation and increasing transnational movements of people, threats to health were becoming rapidly transnationalized, and beyond the capacity of established national and international mechanisms to control effectively. When the short-lived but deadly epidemic of Severe Acute Respiratory Syndrome (SARS) broke out in 2002–3, the responses by WHO as well as various non-governmental actors prompted David Fidler (2003; 2004a; 2004b) to exclaim that an important milestone in global health governance had been reached, namely that post-Westphalian governance had replaced the traditional state-based system. Since then, the impending threat of a worldwide avian flu pandemic has brought together an unprecedented mix of national, international, state and non-state actors in 'emerging governance modalities' around infectious

disease (Neubauer, 2005). In summary, a defining moment in the transition from international to global health involves the emergence of new infectious diseases, their rapid transnationalization and the development of new governance arrangements to address their national as well as human costs.

The shift from international to global health has been demonstrated by worldwide alterations in chronic disease patterns as well, although the global health aspects of chronic disease are not yet as well documented as are those associated with infectious disease (Strong et al., 2006, p. 492). Since the late 1990s, more deaths in the world each year have been caused by chronic diseases, so that currently 'chronic' or 'noncommunicable' diseases such as cardiovascular disease and diabetes account for 60 per cent of deaths worldwide (MacLean and MacLean, 2008); and, except in the African region, 'chronic diseases kill and disable more people than HIV/AIDS, tuberculosis, and malaria' (Spinaci et al., 2006, p. 32). Eighty per cent of these deaths occur in low and middle-income countries (Daar et al., 2007, p. 494). In sub-Saharan Africa, infectious diseases still claim more deaths in the region (mainly because of AIDS) than chronic diseases, but a rapid increase in chronic disease rates in the region means that Africa is now wrestling with a double health burden (Mufunda et al., 2006).

The global epidemiological transition is due in part to demographic shifts (many populations are aging and thus are more susceptible to chronic diseases), but especially in Southern countries, where the diseases manifest more in middle age than in old age as in the North, global political economy forces are largely responsible for the transition. Increased urbanization, which encourages changes in lifestyle associated with the new global division of labor and/or cultural shifts in diet or exercise patterns, are partly responsible, as are lifestyle changes encouraged by trade and/or global marketing (especially increased smoking rates) (Brown, 2002; Popkin, 2006).

Influential international organizations such as the WHO (2005a) and the World Bank (Adeyi et al., 2007) have begun campaigns to raise awareness about the discrepancies in global health burden associated with the epidemiological transition. In response to the growing global tobacco epidemic, for instance, the WHO enacted its first international health treaty, the Framework Convention for Tobacco Control (FCTC), which came into force on 27 February 2005. The FCTC reflects the WHO's concern with the growing global epidemic of tobacco use and tobacco's harmful health, social, environmental, and economic effects. Furthermore, it heralded growing interest in the increasing chronic disease burden, which has been largely neglected to date. Indeed, chronic diseases were overlooked in the preparation of the Millennium Development Goals (MDGs) and have yet to be specified as other health issues have been in this major global initiative.

Increased rates of chronic disease as well as emerging infectious diseases help to expose the impacts of changes in the global political economy on social conditions and welfare. For instance, one of the major impacts on

chronic disease rates has been global trade. Some effects of increased trade may be positive, such as in possible advancements for diagnosing disease, or greater foreign investment in health sectors (Blouin, 2007a). However, to date, many of the effects have been negative, as in the lessening of states' ability, independently, to control and develop their national health policies (Bettcher et al., 2000), decreased access of many people, especially in the South, to affordable drugs (Mulay et al., in this volume), increased availability of unhealthy products such as tobacco (Bettcher et al., 2001) or processed foods with high salt and/or fat content (Popkin, 2006) and increased challenges to worker health and safety (Brown, 2002).

In addition to new endemic and pandemic infectious diseases (and the securitization of these diseases), the emerging worldwide 'epidemic' of chronic diseases and various trade-related health issues, there are several other global health issues. These include the drug trade, the transnational trade in people for prostitution and/or slavery, the health problems of refugees, the rapidly expanding, illegal trade in organs and the emergence of 'surgery vacations' where patients travel to countries to receive cut-rate plastic surgery or cardiovascular treatments. In most if not all of these global health issues disparity is a notable feature; poor people, communities and countries carry a significantly greater burden of global disease and a sizably reduced level of health (CSDH, 2008). In this volume, we argue that the distinguishing feature of these issues as global health items, and their differential impacts, is their source and/or embeddedness in the political economy of globalization. In other words, global health issues are those health issues that have emerged as the result of changes in relations and behaviour of states, businesses and people, and these changes are determined by the recent dominance and contradictions of global neoliberalism.

Global health governance

The inability of the established international health governance system to deal effectively with global health issues prompted Andrew Cooper et al. (2007, p. 3) to declare emphatically that '[g]lobal health is in crisis'. Also, although new governance architecture is emerging to deal with the various issues, the verdict is still out on how effective the new arrangements will be to deal with the health problems of the global era. In particular, structural changes in the neoliberal organizations and principles that have dominated in setting the current global health agenda are unlikely to occur quickly, even if the neoliberal system has entered a crisis phase. Although the current architecture of global health governance will no doubt be altered by the crisis (especially in terms of the respective power of central players), the extent is still uncertain.

To date, the global health governance architecture has conformed, generally, to the pattern of nascent global governance structures in that it involves

a range of actors that interact over several levels from the local through national, international and global. James Rosenau (2005) has described this framework of global governance as involving 'multiple spheres of authority' that interact within an arrangement of 'disaggregated complexity'. In the new complexity, the World Health Organization continues to be a central player in health governance, as it was in the international era. However, it is now only one of several key players in the health governance nexus. Many of the newly engaged actors have not previously been involved, or have been involved only marginally, in health. One of these is the WTO, as noted above. The World Bank is also a relatively new, and highly influential, actor in global health governance and, unlike the WTO, this organization has become involved specifically to influence health outcomes. Since acknowledging in the *World Development Report 1993* that health plays a critical role in economic development, the World Bank has increased its expenditures on health appreciably so that now it is one of the main funders. Between 1990 and 2004, the Bank 'lent nearly \$20 billion and disbursed \$15 billion' to the health sectors of developing countries and it supports 11 global health partnerships (Lele et al., 2004, xiv). Yet, the Bank's role in global health is decidedly contradictory; while it shares the centre of global health governance authority with the WHO, and although it has committed significant resources to solve global health problems, it has also been a major contributor to global social inequities. Indeed, as David McCoy (2007, p. 1500) argues, the Bank's recent decision to devote more of its attention to health sector reform may be 'cause for alarm':

while the Bank's strategy contains much to agree with, its claims to expertise and credibility in the field of health systems are troubling. Indeed, structural adjustment programmes and health sector reforms inspired by the Bank have underpinned many of the current problems in poor countries [and] ... the Bank's continued promotion of proprivate market-oriented policies and its view that health care can be reduced to a set of tradeable commodities and services raises important concerns.

Similarly troubling and controversial is the growing importance of the G8 group of the Organization of the Economic Cooperation and Development (OECD) at the centre of global health governance. Some view the G8's role as constructive. For instance, according to John Kirton and Jenevieve Mannell (2007, p. 115), in the wake of failure of the WHO to deal effectively with global health issues, the G8 'has taken up the challenge' to provide effective leadership through a variety of initiatives. Kirton and Mannell give credit to the G8 for several high-profile global health initiatives, including the Global Fund to Fight AIDS, Tuberculosis, and Malaria, founded in 2001, the G8 Africa Action Plan and the G8 Health Action Plan, as well as specific programmes on infectious diseases such as HIV/AIDS and polio (ibid., pp. 115–16). Kirton

and Mannell's generally positive view of the G8's role in global health governance is not shared by everyone, however. Indeed, others (Schrecker et al.; O'Manique) in the same volume are much less sanguine about the G8's role. As Colleen O'Manique (2007, p. 216) observes, any contributions that the G8 makes to global health governance need to be evaluated '...in the context of the collateral damage caused by its members' attachment to the specific policies governing the global political economy and their enforcement by the IFIs [international financial institutions]....'

While dominant organizations within the neoliberal order, such as the G8 and World Bank, are among the more prominent players in emerging global health governance, other international organizations are also contributors to the new health order. The United Nations General Assembly is one such organization. While it was not much concerned with international health in the past, it became a significant player in global health governance by adopting the Millennium Declaration in 2000, since three of the eight Millennium Development Goals established by the Declaration deal directly with health, while the remaining five target social determinants of health.² The UN Security Council also became involved in global health governance when it identified HIV/AIDS as a significant international security issue in 2000, thus marking the first time that a health issue had been securitized by the major international security body (Holbrooke, 2000). Various other organizations – UNICEF, UNDP, UNFPA, ILO, IMF³ – are also featured in global health governance, although as second-tier players that are less prominent than central organizations such as the WHO or World Bank (Dodgson et al., 2002, p. 22).

Bilateral relations are also an important part of the emerging global health governance architecture. Most of, if not all, the major industrialized countries now commit resources individually to research and project initiatives under the rubric of 'global health' (see the MacLean and MacLean chapter in this volume). Among these, the United States wields probably the greatest influence in setting the global health agenda, since it is the most significant state donor of funds to global health projects and research (see the chapter by Rodney Loepky). For instance, when the President's Emergency Plan for AIDS Relief (PEPFAR) was launched in 2003, committing \$15 billion over 5 years to the fight against HIV/AIDS, it was 'the largest commitment ever by a single nation toward an international health initiative' (PEPFAR website). By 2005, PEPFAR was providing 70 per cent of the US\$3 billion per year being transferred by all actors engaged in the fight against HIV/AIDS (Bernstein and Sessions, 2007). Some scholars have argued, however, that PEPFAR is designed primarily to serve US domestic interests and that the US involvement in global health generally is motivated as much or more by concerns to protect national interest (or regime interest) than by humanitarian, human rights or human security objectives (e.g., see Stuckler and McKee, 2008). Motivation is impossible to discern with certainty, and it is

probable that mixed motives are driving policy. However, it is clear that a central theme in US government publications on global health is the threat of emerging diseases to American security, as recent realignments of US foreign policy include increased spending on response preparedness against increased threats from bioterrorism and emerging infectious diseases, including HIV/AIDS (HHS, 2001).

Many of the most influential non-state actors in global health are also largely concentrated in the US. Within the business sector, this includes pharmaceutical companies, which have been among the most controversial of global health actors. For instance, they have come under heavy criticism for taking financial advantage of the global market while neglecting diseases of the South, including chronic diseases. As Trouiller et al. (2001, p. 946) assert:

Today drug development is confined almost exclusively to a consolidated and highly competitive multinational drug industry driven by profit and subject to the laws of a globalized market economy. Market forces inevitably skew the direction of drug R&D [research and development] towards those diseases and patients (customers) that assure the highest financial returns (Sachs, 1999). In 1999, North America, Europe and Japan accounted for 82.4 per cent of the world pharmaceutical market (valued at US \$337 billion), while Africa and Asia, representing more than two-thirds of the world population, only accounted for 10.6 per cent of the market....

Another major concern expressed about pharmaceuticals is the pressure they exert to keep drug costs high – prohibitively so for many individuals in the South. The most widely publicized case involved the attempt by a group of companies in the late 1990s to block South Africa's compulsory licensing of generic drugs (Kumaranayake and Lake, 2002, p. 88). Intense opposition led by the South African coalition, Treatment Action Campaign (TAC), and supported by powerful international NGOs as well as the WHO and some Western European countries (see TAC website) eventually persuaded the pharmaceutical companies to withdraw their petition. Buoyed by this success, the campaign to make antiretroviral drugs more widely available continued to expand⁴ and witnessed some success in the adoption in 2001 of the Doha Declaration on the TRIPS Agreement, which supported '...WTO Members' right to protect public health and, in particular, to promote access to medicines for all' (WTO, 2001, p. 1). A subsequent General Council Decision in 2003 approved an amendment to the 2001 Declaration (the Pérez-Motta text) to facilitate '...effective use of compulsory licensing by Members with no or insufficient manufacturing capacities in the pharmaceutical sector' (UNCTAD/WTO, 2005, p. 1). The following year, Canada's Bill C-9 was the first national legislation to enact compulsory licensing to

export essential medicines to countries that could not produce their own (Government of Canada, 2004).⁵

Although the greater flexibility introduced into the WTO patent regulations has helped somewhat to increase the availability of needed drugs, as Roy Love (2007) points out, it has not solved all problems of access. He points out that the regulatory framework is onerous and many developing countries do not have the capacity to put 'TRIPS-compliant legislation' in place easily or soon (p. 11). Also, despite lower prices of drugs under the improved arrangements, '...even the lowest quote of about US\$140 per annum (mid-2005) [for a common ARV drug] remains out of reach of most households in the developing world' (*ibid.*, p. 212). Finally, as others have observed, there is inadequate infrastructure capacity and/or political will to distribute drugs in some countries, even when cheaper drugs are available (Richey, 2008).

Despite lingering problems, the ongoing efforts to resolve the continuing problems with developing countries' access to drugs indicate potentially hopeful aspects of emerging global health governance; that is, the increasing role of socially responsible civil society organizations. This role tends to be complicated, as the interactions are national-international-grassroots, as João Biehl (2007) explains in his detailed account of the events and processes by which Brazil was able to introduce free retroviral treatment for the country's HIV/AIDS victims. In this age of intense power and influence of pharmaceutical companies ('pharmaceuticalization', as he terms it), he argues that '[a]gainst all odds, Brazil invented a public way of treating AIDS' (p. 1084). This 'public way' was a 'state-society synergy' that emerged within the dialectics of the 'political economy of pharmaceuticalization' and culminated in the state's decision and ability to deliver free HIV/AIDS drugs (p. 1094).

The increasing involvement of civil society organizations and movements and the partnerships between state and non-state actors is one of the defining characteristics of global health governance. Some NGOs stand out as significantly influential actors. As noted above, TAC in South Africa is one example in the local/national arena, but there are myriad local/national NGOs and faith-based organizations contributing to the debates and practices. (For example, Biehl (2007, p. 1091) indicates that there are 500 AIDS NGOs, alone, registered in Brazil.) Likewise, there are numerous international NGOs now contributing to global health governance. To illustrate with one well-known example: MSF has worked since the late 1990s to establish a coalition of state and non-state actors to provide greater and cheaper access to medicine; it 'now has more than 60 000 people on treatment for HIV/AIDS in 32 countries around the world'; and in 2006 it launched the Drugs for Neglected Disease Initiative for delivering not-for-profit drugs (Orbinsky, 2007, pp. 34–5).

Major initiatives of global health governance now, almost invariably, are characterized by leadership that includes mixed actor coalitions. Prominent

examples of these are the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Roll Back Malaria Partnership, the Stop TB Partnership, the International AIDS Vaccine Initiative (IAVI) and the Global Alliance for Vaccine and Immunization (GAVI). The phenomenal growth in numbers of these various public private partnerships (PPPs) has stimulated considerable analytical attention over the past decade, and it is the focus of several chapters in this volume. Yet, while such partnerships have generated exceptional attention to and resources for global health, their efficacy remains open to question. Several disquieting issues include: agenda setting (powerful business members of the partnerships may be motivated more by profit than by human rights and needs or global public goods); coordination (problems arise in managing actors from different sectors; also with multiple players now in the field both redundancies and gaps exist in programming); and accountability (current legal structures are inadequate to regulate these new forms of governance). Until these issues are resolved, questions will remain about the efficacy of PPPs. As the organizers of a recent conference on PPPs in global governance asked: 'What are they all about, and do they represent a critical, lasting strategy?' (Global Health Council, 2008).

Philanthropic individuals and organizations have become increasingly important actors within the new private–public governance arrangements. Some, such as personalities like Bono, have 'public appeal [that] can influence, if not shape, international political agendas' (Orbinsky, 2007, p. 37), while others, especially major financial donors like the Bill and Melinda Gates Foundation, can shape as well as influence. The influence of the Gates Foundation in global health, already well established, was enhanced significantly in 2006 with the infusion of US\$37 billion from financier Warren Buffett. With assets now of approximately US \$60 billion, the Foundation's annual donation of around \$3 billion to global health research and aid makes it a major player in global health (Okie, 2006, p. 1084). Media coverage of the Gates' contributions has been extensive and almost invariably positive; however, other actors within the global health field are less sanguine. Indeed, as David Fidler (2007, p. 2/18) observes, '...governing Bill Gates may prove as challenging in its own way as governing the United States in terms of global health' (Fidler, 2007, p. 2/18). The main concern is that the amount of funds donated by the Foundation gives it disproportionate power to influence the directions of the global health research and policy agendas (*The Economist*, 2008). The Foundation's main interest has been in technical solutions to health problems, and excessive emphasis on the bio-technical approach to health distracts from addressing social determinants. The Gates Foundation recently announced support for an anti-tobacco initiative,⁶ which may indicate a new direction for the organization, but to date the Foundation has provided few funds for social determinants. It has been criticized, for instance, for not funding projects to investigate and/or develop capacity in national governments for delivering health services and

promoting healthy communities. Generous donations of funds for biotechnical solutions may be counterproductive, and are certainly administered inefficiently, in developing countries that lack capacity to absorb and manage large sums (Ramiah and Reich, 2005).

The myriad actors, their complex interactions, and the range of problems as well as possibilities are features that define the emergence of global health governance. David Fidler (2007, p. 15) argues that 'the sheer expanse of international relations in which global health now features undermines the feasibility of achieving all-encompassing architecture for global health governance'. And, indeed, the picture of global health governance that emerges is more consistent with Rosenau's description of 'multiple spheres of influence' in a 'disaggregated complexity' than it is with any discretely organized governance structure. This complex, multi-actor, multi-layer, multidimensional arrangement of global health governance that is emerging can offer unprecedented possibilities and opportunities for innovation as well as cooperation to improve health outcomes throughout the world. However, unless the dominant actors begin to put more emphasis on the social determinants of global health, the potentials of the system will not be realized. The emerging structures of global health governance, in themselves, point to important dimensions of social determinants that call for better understanding. Global health issues are largely socially determined, the result of recent changes in global political economy and the shift from a predominately international to an increasingly global order. Similarly, the global health governance architecture that is developing is dominated, but not determined entirely, by the most powerful actors in the global political economy. Conditions of inequality and inequity are among the main determinants of the current pattern of disease burden in the world, and the unequal disease burden, in which those who shoulder the heaviest burden receive the lowest amount of resources, severely challenges the logic and authority of the dominant order.

The chapters in this volume question the ways in which that order is influencing health outcomes. In all, the underlying concern is to add to current debates about the concepts and problems of global health, the major players currently involved and the types of governance arrangements that are emerging in the global health area. Specifically, they address the political economy of global health by examining how hegemonic actors and contemporary conditions in a globalizing world order are contributing and/or responding to global health and disease.

Structure of the book

Part II examines the roles and responses of state and interstate actors in the global health nexus. Ted Schrecker begins by examining the G7/G8 as one of the major players in global health governance. He argues that, since the

increasing commodification of health in a global marketplace is undermining health equity, the G7/G8 governments and electorates who place them in office have 'redistributive obligations' and he identifies specific 'policy entry points' where responsible action could begin. However, as Rodney Loeppey's chapter points out, the ability to take advantage of the policy entry points by any actor is compromised by power inequalities among the major actors. Loeppey observes that the United States, in particular, exerts profound effects on global health through the powerful health 'complex' that is emerging in that country. Given that powerful actors such as the US and the G7/G8 have considerable control over the governance framework and agenda, weaker states are in a position of having to respond to conditions and exigencies that stronger players are able to manipulate. However, Colleen O'Manique argues that a national government need not only maneuver, but can also to some extent influence behaviour within the emerging global health governance complex. Her case study of Canadian foreign policy on global health examines the contradictory roles the country plays by promoting the commodification of global public goods while also supporting initiatives such as the Global Fund for HIV/AIDS, Tuberculosis and Malaria. Meanwhile, Pieter Fourie's case study from a Southern perspective explores the South African state's ability to respond to the HIV/AIDS epidemic. He argues that, although evidence does not support the assumption that HIV/AIDS necessarily contributes to state fragility, it does create a profound governance challenge, and thus a 'moral imperative ...for states and individuals to maintain a sense of urgency and purpose'. In turn, this reinforces the need for prominent global health actors to address the social determinants along with the biological imperatives of disease.

Part III of the volume explores transformative factors in the transition from international to global health governance. The chapter by Wolfgang Hein and Lars Kohlmorgen explores the expanding role of non-state actors in global health governance. Based on a study of the pressure that civil society organizations (CSO) exerted on the Doha Declaration on the TRIPs Agreement and Public Health, Hein and Kohlmorgen conclude that CSOs 'successfully use their discursive power to push for the implementation of these norms'. The subsequent chapters in the section investigate various issues involving what Carmen Huckel Schneider refers to as the 'innovative forms of governance' that have emerged in global health. In seeking to uncover the origins of the contemporary development of PPPs, as one of these innovative forms, Huckel Schneider highlights five discourses of public health governance that provide historical rationales for the contemporary development of PPPs. An increased role for private philanthropic foundations has been a feature of the recent innovations, and Michael Moran's chapter investigates this role through a case study of the Rockefeller Foundation's support for Product Development Partnerships (PDPs) throughout the 1990s and early 2000s. Sonja Bartch explores the critical issues of legitimacy and

effectiveness in global health governance. Through a case study that regards the operations of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) from the perspective of Southern partners, Bartch argues that Southern participation enhances the legitimacy of the GFATM, but that effectiveness is compromised to some extent by the partnership model. Siri Bjerkreim Hellevik's chapter extends the investigation into the issue of effectiveness. She argues that, in areas where engagement is now occurring, a continuing lack of coordination among the various donors – despite efforts to alleviate the problem – is a serious impediment to efficiency. Focusing on global HIV/AIDS programmes operating in Africa, she argues that, in fact, there is a 'crisis of implementation'.

Part IV explores several practical implications of current global health governance. The first chapter in this section, by Sandra MacLean and David MacLean, explores the present state of global health research, and argues that business interests dominate in setting the research agenda, which is much more directed towards biotechnical innovation than social determinants. Business interests also underscore Valbona Muzaka's chapter, which is concerned with the production of pharmaceutical products. Muzaka examines TRIPs as both a legal structure and an international norms setter and considers the effects of TRIPs on the public health of developing countries. Shree Mulay, Eowynne Feeney and Daya R. Varma continue the investigation of trade issues and global health. According to these authors, as the result of changes in WTO rules in 2005, treatments for neglected global diseases are potential growth industries for the South. However, in order for the medicines produced to be affordable to poor members of populations, national governments must step up efforts to produce policies that enhance complementarity between social need and global opportunity. Sherri Brown examines the ethical dimensions that arise from the business of global health through an examination of practices of three types of global PPPs operating in Africa (African Comprehensive HIV/AIDS Partnership, International AIDS Vaccine Initiative and Accelerated Access Initiative).

The contributors to this volume approach the issue of global health from different methodological frameworks and theoretical perspectives. Yet, the authors are united in a common concern to highlight the health inequalities and inequities that characterize global health in the contemporary period. Also, the authors, through different lenses, expose how political economy factors are both contributing to current global health problems and supporting governance arrangements that produce inadequate solutions.

Notes

1. Progress is being made in developing more effective interdisciplinarity; refer to the Oslo Ministerial Declaration as one example (see <http://www.diplomatie.gouv>).

fr/en/france-priorities_1/health_1102/events_2135/oslo-ministerial-declaration-march-20-2007_8924.html).

2. Goals 4, 5 and 6 deal directly with health and are, respectively, to 'reduce child mortality', to 'improve maternal health' and to 'combat HIV/AIDS, malaria and other diseases'. The other goals are to 'eradicate extreme poverty and hunger', to 'achieve universal primary education', to 'ensure environmental sustainability' and 'to develop a global partnership for development' (see <http://www.un.org/millenniumgoals/>).
3. These are acronyms for, respectively, the United Nations Children's Fund, the United Nations Development Programme, the United Nations Population Fund, the International Labour Organization and the International Monetary Fund.
4. As well as legislative developments to promote better access to antiretrovirals, there have been several other initiatives to facilitate the delivery of these drugs. One of the most highly developed is WHO's '3 by 5' initiative, established to provide antiretroviral treatment (ART) to 3 million by 2005 (WHO, 2003). The target was not met by 2005 (only 1.3 million were receiving treatment), although some scholars note that 'treatment centres and programmes report good initial responses' (Gilks et al., 2006, p. 505).
5. This legislation was prompted by fears of a pending global epidemic of avian flu and the realization that Hoffman-LaRoche's patent for Tamiflu would limit supplies of this drug, deemed to be the most effective treatment for the disease.
6. The Foundation announced that it would provide financial support to the Bloomberg Initiative to Reduce Tobacco, founded by the New York mayor, Michael Bloomberg (see the Foundation's website, <http://www.gatesfoundation.org/press-releases/Pages/bloomberg-gates-tobacco-initiative-080723.aspx>)

Index

- AAI, *see* Accelerating Access Initiative
- Abuja Declaration, 157
- Accelerating Access Initiative, 211–18, 222–4
- access to medicines, 12, 177
- accountability
- concept of, 140
 - in democracies, 78–9
 - of development aid, 141
 - of G-8, 22
 - governance networks and, 13, 157–9, 229
 - of markets, 25
 - of philanthropic organizations, 124
 - of PPPs, 140, 212–14, 217
 - supported by NGOs, 110
- accountability mechanisms of
- GFATM, 141
- Adam Smith, 71, 80, 81
- Afghanistan, 57
- Agreement on Trade-Related Aspects of Intellectual Property Rights, 28, 32, 183, 224
- AIDS, *see* HIV/AIDS
- AIDS governance, 73, 159
- Alma Ata Declaration, 53, 95, 111
- antiretrovirals, 12, 62, 95–6, 98–100, 102, 132, 214–16
- Argentina, 34, 189
- ARVs, *see* antiretrovirals
- Australia, 34, 66, 170, 192
- avian influenza, 54, 64, 65
- Axworthy, Lloyd, 55
- bio-accumulation, 44, 51–2
- biomedical industry, 39, 42, 44–5
- biomedical model, 166, 177, 180, 233
- biomedical research, 41–3, 174, 177, 179
- biotechnology, 39, 41, 43, 44, 46, 51, 170, 175
- Biotechnology Industry Organization (BIO), 44, 47, 51
- bioterrorism, 11, 178
- Black Report, 167
- Bono, 13, 206
- Brazil, 12, 33, 37, 96, 97, 102, 103, 160, 189, 193, 197
- Britain, 54, 198, 199–200
- Canada, 11–12, 36, 37, 53–66, 168, 169, 189, 196–9, 202, 208, 230
- Canadian Coalition for Global Health Research, 172
- Canadian Council on International Cooperation, 57
- Canadian Department of National Defence and International Trade, 56, 64
- Canadian Generic Pharmaceutical Association, 199
- Canadian Institute for Health Research, 169, 182
- Canadian International Development Agency, 56, 58–9, 60, 61, 169
- cancer, 100, 114, 165, 178, 201
- capitalism, 40–1, 176, 235
- cardiovascular disease, 7, 114, 178, 203
- Chile, 37, 180, 189, 216
- China, 23–4, 33, 34, 64, 168, 170, 201
- chronic disease, 3, 7–8, 11, 70, 178, 181, 208, 227, 230, 232
- CIA, *see* US Central Intelligence Agency
- CIDA, *see* Canadian International Development Agency
- Cipla, 200–1, 207
- civil society, 5, 6, 12, 15, 27, 40, 41, 53, 56, 60, 61, 79, 87, 89, 94, 96, 98, 100, 101, 102–3, 110, 123, 130, 136, 139, 147, 148, 159, 166, 170, 171, 173, 176, 180, 190, 215, 230
- civil society organisations, 5, 12, 15, 27, 53, 56, 61, 87, 88, 89, 90, 92, 93, 94, 95, 96, 97, 98, 100, 101–2, 147, 171, 215
- Clinton Foundation, 98, 101, 102, 121, 206
- Colombia, 189
- Commission for Africa, 24, 26, 31
- Commission on Macroeconomics and Health, 25, 132

- Commission on the Social
 Determinants of Health, 37, 167,
 168, 233, 236
- competition state, 25, 33
- Consumer Project on Technology, 187
- Costa Rica, 189
- Country Coordinating Mechanism
 (CCM), 62, 98, 134–7, 141–2, 148,
 150–2, 159
- country ownership of development
 initiatives, 130, 131, 135, 137,
 142, 156
- ‘crisis of implementation’, 16, 145, 157,
 160, 231, 232
- CSDH, *see* Commission on the Social
 Determinants of Health
- Cuba, 59–60
- debt relief, 22, 25, 27, 30–1, 37
- democracy, 58, 73, 78–9
- developing countries, 9, 12, 14, 16, 26,
 28, 32, 33, 35, 37, 58, 63, 89, 95, 96,
 97, 98, 99, 114, 115, 121, 125, 126,
 131–5, 170, 172, 181, 186, 187, 188,
 189, 191, 193, 194, 196–7, 202, 206,
 207, 210, 212, 215, 216, 217, 218,
 219, 227, 228, 234, 236
- development aid, 145, 150, 158
- development assistance, 21, 22, 24,
 25–7, 29, 30, 32, 35, 36, 54, 58, 59,
 65, 66, 123, 234
- DFAIT, *see* Canadian Department of
 National Defence and International
 Trade
- Diflucan partnership, 211, 212, 213,
 214, 215, 218–19, 223, 224
- direct-to-consumer advertising, 49–50
- Doha Declaration, 11, 15, 97, 102, 184,
 187, 189, 190, 191, 192, 193, 194, 202
- Doha Ministerial, 184
- Ebola disease, 6, 231
- economic, cultural and social rights, 87,
 90–1, 100, 103
- economic development, 9, 55, 90, 111,
 125, 132, 168, 223
- economic growth, 23–4, 26, 71, 80, 82,
 132, 177
- education, 17, 22, 25, 59, 60, 61, 64, 83,
 105, 107, 177, 179, 185, 210, 222,
 229, 233
- electoral processes, 78, 79
- epistemic communities, 115
- ESC, *see* economic, cultural and social
 rights
- European Partnership for Global
 Health, 170
- European Union, 29, 66, 103, 234
- ‘ever-greening’ of patent medicines,
 198, 204
- failed and/or failing states, 69, 70,
 73, 83
- FAO, *see* Food and Agriculture
 Organization
- FDA, *see* US Food and Drug Agency
- Food and Agriculture Organization,
 64, 185
- foreign policy, 11, 15, 36, 53, 54–8, 59,
 63, 65
- fragile states, 72, 73, 83
- free trade agreements, 188, 189, 192, 193
- G7, 14, 15, 21, 30, 32, 35, 36, 53, 172
- G8, 9–10, 14, 15, 21–2, 24, 25, 29–37,
 53, 54, 61, 66, 96, 97, 98, 101, 102,
 133, 142
- Gates Foundation, 13, 98, 101, 102, 110,
 112, 117, 118, 124, 138, 148, 170,
 172, 176, 181, 206
- GAVI, *see* Global Alliance for Vaccines
 and Immunization
- General Agreement on Trade in
 Services, 28
- generic drugs, 11, 54, 186, 197, 199
- German National Commission on
 Global Change Research, 169, 180
- Germany, 31, 36, 51, 198, 200, 235
- GIST, 149, 153–5, 156, 157, 160
- Global Alliance for Vaccines and
 Immunization, 13, 62, 108, 112,
 117, 124, 222
- Global Forum for Health Research,
 171–2, 173, 181
- Global Fund to Fight AIDS, Tuberculosis
 and Malaria, 9, 13, 15, 16, 29, 53,
 62, 69, 98–9, 102, 104, 107–8, 121,
 130–43, 144, 145, 146, 147–8, 149,
 150–2, 153, 154, 155, 156, 158, 160,
 176, 188, 236
- global health, defined, 7–8
- global health analysis, 3

- global health governance, 3, 4, 6, 8–10, 12, 14–16, 53–4, 94, 98, 110, 114, 116–17, 119, 120, 129, 130–1, 143, 157, 211, 213, 214, 219, 221–3, 227, 229–33, 236
- global health paradigm, 4, 6
- Global Health Research Initiative, 169, 180
- Global Polio Eradication Initiative, 62
- Global Programme on AIDS, 60–1
- global public goods, 13, 15, 33, 116, 211, 220, 222
- global public private partnership, 62, 94, 98, 99, 102, 130–1, 139–41, 143, 210–14, 220–2
- Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, 149, 150, 153, 154, 156, 157, 158, 159, 160
- global trade, 8, 21, 65, 183
- global warming, 4, 133
- governance networks, 117, 157–8
- HAI, *see* Health Action International
- Haiti, 26
- harmonization, 57, 141, 142, 145, 149, 150, 153, 154, 156, 158, 192
- Health Action International, 96, 187
- Health Canada, 169, 198
- health care delivery, 39, 40, 41, 42
- Health Communication Partnership, 107
- Health for All, 53, 95, 100–1, 108, 171, 209
see also Alma Ata Declaration
- health research, 13, 16, 54, 97, 114, 115, 165, 166, 167, 169, 170–9, 180, 181, 212, 233
- health risks, 33, 211, 220, 233
- health-industrial complex, 39–40, 44, 45, 48, 50, 51
- HIPC (Heavily Indebted Poor Countries), 30–1
- HIV/AIDS, 6, 7, 9–17, 33, 28–9, 53–4, 60–2, 64, 67–83, 91, 95–103, 107, 110, 116, 118, 119, 121, 125, 128, 130–7, 140–2, 144–61, 170, 176, 178, 181–2, 186–8, 190, 193, 195, 202, 205–6, 214–18, 223, 228–9, 231, 232, 234
- Hong Kong Ministerial, 184
- hookworm, 123, 127
- Human Genome Project, 44, 46
- human rights, 10, 13, 37, 54, 56, 58, 59, 73, 77, 87, 90–1, 93–4, 96, 183, 185
- human security, 10, 54–7, 59, 63, 65, 69, 120
- IDRC, *see* International Development Research Council
- IGOs, 89, 92, 93, 94, 96, 97, 98, 99, 100, 102
- IMF, *see* International Monetary Fund
- India, 23, 24, 33, 34, 37, 99, 123, 168, 189, 197, 199–209
- inequality, 14, 34, 37, 97, 159, 167–8, 173, 176, 217, 227–8, 233
- infectious diseases, 3, 6–7, 8, 9, 11, 29, 33, 54, 64, 91, 95–6, 98, 101, 114, 116, 118, 133, 173, 212, 214, 221
- intellectual property rights, 28, 45, 54, 96, 97, 99, 100, 101, 102, 104, 111, 183, 184–91, 194, 195, 223
- International AIDS Vaccine Initiative, 13, 16, 107, 118, 119, 125, 126, 127, 128, 223
- International Covenant on Economic, Social and Cultural Rights, 90, 91, 103
- International Development Research Council, 169
- international health, 3, 5–6, 7, 8, 10, 94, 103, 173, 174, 180, 181, 229, 231
- International Monetary Fund, 10, 17, 21, 30
- international political economy, 3, 4, 5, 167, 178, 179, 180
- International Red Cross, 109
- international relations, 3, 4, 5, 14, 32, 33, 36, 38, 87, 92–3, 103, 167, 178, 180, 230
- IPRs, *see* intellectual property rights
- Iraq, 27, 29, 57
- Italy, 4, 31, 36, 125, 198
- Japan, 11, 31, 36, 133, 138, 142, 185, 188, 201, 203, 207
- Kaiser Foundation, 170, 181
- Kimberly Process, 55
- leprosy, 205, 206, 207, 209
- life expectancy, 74, 76, 132

- Lisbon Agenda for Europe, 191
 long-wave event, 67, 68, 82, 116
 low-income countries, 27, 28, 30, 37, 168
- malaria, 6, 7, 17, 33, 61, 62, 64, 107,
 118, 121, 130, 131, 132, 135, 137,
 140, 176, 181, 202, 205, 206, 207,
 210, 211, 212, 214
- Malawi, 68, 79, 151
- MAP, *see* Multi-country HIV/AIDS
 Programme for Africa
- Marx, 71, 80, 81, 122
- MDGs, *see* Millennium Development
 Goals
- MDRI, *see* Millennium Development
 Goals
- Médecins Sans Frontières, 12, 96, 103,
 132, 187, 207, 215, 234, 236
- Medical Research and Development
 Treaty, 97
- Medical Research Council, 174, 257
- Medicare Modernization Act, 51
- Medicines for Malaria Venture, 206
- Mexico, 33, 65, 123
- middle-income countries, 7, 25, 27–8,
 37, 99, 132, 215
- Millennium Development Goals, 7, 10,
 24, 61, 123, 227–8, 233
- Millennium Project, 26–7
- MMV, 206
- MNCs, *see* Multinational Corporations
- Mozambique, 30, 68, 151–2, 160
- MSF, *see* Médecins Sans Frontières
- Multi-country HIV/AIDS Programme for
 Africa, 69, 99, 146, 147, 149,
 151, 155, 156, 158
- Multilateral Debt Relief Initiative, 30–1
- Multinational Corporations, 197, 199,
 200–3, 207–8
- national health, 8, 30, 63, 95, 175, 211,
 220, 233
- National Institutes of Health, 42–4,
 169, 172, 174, 180–1
- National Intelligence Council, 70, 133
- national security, 54–5, 57, 63, 69–70, 178
- Natural Sciences and Engineering
 Research Council, 169
- neoliberalism, 5, 8, 54, 58, 109–10,
 119, 128
- NEPAD, 61–2
- new variant famine, 81–3
- NIC, *see* National Intelligence Council
- Nicaragua, 59
- Nigeria, 23, 27, 29, 79, 156, 160, 203
- NIH, *see* National Institutes of Health
- non-state actors, 6, 11–12, 15, 53, 87–9,
 92–4, 98, 101, 109, 113, 119–20,
 130–1, 134, 136, 140–2, 168, 183–4,
 187, 194–5, 212, 223, 231–3
- norm-building, 87–91, 93–7, 99, 101–3
- Norway, 35, 168–9, 181, 234
- Norwegian Forum for Global Health
 Research, 169
- NSERC, *see* Natural Sciences and
 Engineering Research Council
- OECD, *see* Organization of Economic
 Cooperation and Development
- OGAC (Office of the Global AIDS
 Coordinator), 148, 156, 160, 161
- Organization of Economic Cooperation
 and Development, 9, 29, 32, 42,
 98, 230
- Oxfam, 187, 207, 215, 234
- PAHO, *see* Pan-American Health
 Organization
- Pakistan, 189
- Pan-American Health Organization,
 59, 64
- pandemic preparedness, 63–5
- Paris Declaration on Aid Effectiveness,
 62, 142, 145, 150, 160
- patent, 12, 17, 43–7, 50, 63, 97–103,
 175, 183–7, 190–209, 215, 217, 219,
 223–4, 234
- Patented Medicine Price Review Board,
 198–9
- PDUFA, *see* Prescription Drug User Fees
 Act
- PEPFAR, *see* President's Emergency Plan
 for AIDS Relief
- Pfizer, 47, 203, 211, 218–19, 224
- pharmaceutical companies, 11, 12, 51,
 121, 126, 129, 170, 190, 193, 200,
 202–4, 207–8, 215, 217–18, 221, 234
- pharmaceutical industry, 43, 48, 62, 99,
 127, 175, 186, 189–90, 197–8,
 201–2, 208

- Pharmaceutical Research and Manufacturers of America, 43, 44, 50–1, 170, 188, 195
- pharmaceuticals, 11, 43, 48, 170, 176, 183–95, 200–2, 207, 211, 214–16
- philanthropy, 13, 15, 118–29, 170–1, 202, 206, 232
- Philippines, 189
- PhRMA, *see* Pharmaceutical Research and Manufacturers of America
- PMPRB, *see* Patented Medicine Price Review Board
- policy entrepreneur, 127, 129
- political economy of global health, 4–8, 14, 65, 119, 127, 166–9, 171, 173, 178–80, 229
- ‘political economy of pharmaceuticalization’, 12
- political economy of US health, 40, 47
- political instability, 72, 96, 103, 133
- poor health, 53, 63, 65, 117, 168, 212, 229
- Post-Washington Consensus, 132
- poverty, 22–6, 28–9, 31, 34–5, 37, 56–61, 66, 73, 79, 89, 95–6, 101, 130, 132–4, 153, 167, 176, 179, 186, 210, 227, 233, 236
- PPPs, *see* public-private partnerships
- Prescription Drug User Fees Act, 48–9
- President’s Emergency Plan for AIDS Relief, 10, 69, 99, 101, 102, 103, 137, 145–9, 152–61
- price control, 51, 196, 198, 202
- primary health care, 53, 111
- primary norms, 87–8
- Project Bioshield, 44
- PTO, *see* Patent and Trademark Office
- public health intervention, 29, 77
- public-private partnerships, 4, 13, 15–16, 62, 98, 102, 105–17, 118–46, 176, 210–16, 220–4, 232
- R&D, *see* Research and Development
- Ranbaxy, 199, 202–8
- redundancy, 77, 146, 149–50, 152, 159
- Research and Development, 11, 97, 99, 100, 102, 118, 121, 126, 170, 172, 175, 196–200, 200–9
- resources, 14, 18, 21, 25, 31, 37, 39, 42, 43, 45, 50, 81, 89, 92, 109, 125, 127, 128, 140, 142, 151, 154, 159, 160, 168, 188, 198, 208, 212, 217, 218, 223, 225, 226, 227, 233, 235, 238, 242, 244, 246, 252, 255, 257, 258, 259, 262, 267, 273, 274, 288, 291, 294, 312, 317
- RF, *see* Rockefeller Foundation
- Rockefeller Foundation, 15, 42, 109–10, 118–19, 123–9
- Rotary International, 109
- SARS, 6, 33, 54, 63–5, 96, 103, 116, 178, 227, 231
- Saudi Arabia, 34
- scarcity, 35
- Seattle Ministerial, 187
- securitization, 8, 10, 57, 68–70, 73, 168
- security, 10–11, 33, 39, 53–66, 68–84, 96, 101, 103, 120, 133, 168, 178, 220, 222, 229, 235–6
- Security and Prosperity Partnership, 65
- social class, 167
- social condition, 7, 33, 166–7, 179, 232
- social determinants of health, 22, 28, 63, 110, 115, 168, 174, 221–2, 227, 233–6
- social science, 169, 174, 178, 180, 223
- social welfare, 55, 71
- South Africa, 11, 12, 15, 33, 34, 68, 74, 81, 190, 197, 215, 218–19, 230
- South Korea, 34
- SPP, *see* Security and Prosperity Partnership
- SSHRC, 169, 223
- starvation, 101
- state fragility, 15, 67–83
- state regulation, 48, 131
- structural adjustment, 9, 53, 109, 111, 119
- sub-Saharan Africa, 7, 24, 26, 27, 31, 60, 77, 79, 91, 131, 227–8, 234
- subsidiary norms, 87–9, 231
- Swaziland, 68, 74, 76, 151
- Sweden, 35, 168, 198, 234
- TAC, *see* Treatment Action Campaign
- Tamiflu, 17, 204–5
- Tanzania, 68, 151
- tariff, 28, 185
- TB, *see* tuberculosis
- technical capacity, 153–4, 159
- Ted Turner Foundation, 110

- Thailand, 100, 189, 193, 219
- Three Ones, 144–6, 148, 153, 157–9
- Trade Promotion Authority Act, 191
- travel, 8, 33, 136
- Treatment Action Campaign, 11, 12, 219
- Tri-Council, 169
- TRIPS, 11, 15–16, 96–7, 101–2, 109, 183–95, 198, 202, 204, 208
- tuberculosis, 13, 15, 16, 29, 33, 53, 62, 96, 98, 102, 107, 121, 130, 131, 132, 135, 140, 145, 151, 188, 202, 212, 223, 228
- Turkey, 189
- UN Food and Agriculture Organisation, 64, 185
- UN Millennium Project, 24, 26
- UN Security Council, 10, 21, 96
- UNAIDS, 61, 67, 69, 77, 96, 101, 102, 110, 133, 135, 137, 141, 147, 149, 150, 152–5, 211, 216
- UNDP, 10, 56, 153, 220
- UNICEF, 10, 62, 99, 102, 121
- United States, 10, 15, 32, 34, 39–40, 42–5, 48, 51, 55, 59, 69, 73, 118, 133, 156, 219, 234
- universal access, 87, 95, 97–9
- US Central Intelligence Agency, 70
- US Congress, 41–3, 158, 190–1
- US domestic interests, 10, 39
- US Food and Drug Agency, 45, 48–50
- US Patent and Trademark Office, 45, 46
- US Social Science Research Council, 169
- USTR, 189–90, 193
- vulnerable populations, 64, 197, 207
- Warren Buffett, 13, 118
- Wellcome Trust, 170, 181
- WHO, *see* World Health Organization
- WIPO, *see* World Intellectual Property Organization
- World Bank, 7, 9, 10, 21, 23, 30, 31, 53, 69, 99, 101, 102, 105, 109, 111, 121, 130, 135, 137, 145–54, 168, 212
- World Conference on Human Rights in Vienna, 90
- World Economic Forum, 120–1
- World Health Assembly, 57, 95, 97
- World Health Organization, 6, 9, 25, 34, 60, 105, 111, 114, 122, 132, 182, 216, 221, 231
- World Intellectual Property Organization, 102, 184, 185, 188
- WTO, *see* World Trade Organization
- World Trade Organization, 9, 11–12, 16, 32, 47, 51, 93, 96–7, 101–2, 111, 183–5, 187–94, 197–8, 201–2, 208
- yellow fever, 123, 127
- youth bulge, 74, 76, 83