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Global Health Governance: Conflicts on Global Social Rights

Wolfgang Hein and Lars Kohlmorgen

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Editor of the Working Paper Series: Bert Hoffmann <hoffmann@iik.duei.de>

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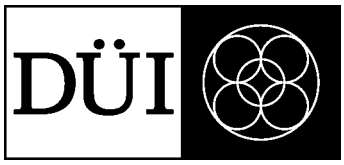
Deutsches Übersee-Institut/German Overseas Institute
Neuer Jungfernstieg 21
D-20354 Hamburg
Germany
E-mail: duei@duei.de
Website: http://www.duei.de



GOI-WP-07/2005

Global Health Governance: Conflicts on Global Social Rights*

Abstract

This paper analyses the impact of new institutional structures in global health governance on the realization of social rights in poor countries. Meanwhile, health is broadly seen as an import precondition for social and economic development. This leads to an integration of the "diseases of the poor" (basically infectious diseases) into strategies of fighting poverty. Considering the example of global HIV/AIDS politics, the paper argues that new governance modes increase the participation of civil society groups and affected communities, but that they are also frequently instrumentalised by powerful actors to pursue their particular interests. In fact, increasing resources are mobilized for the fight against poverty related diseases. The paper concludes that global health governance is characterized by a combination of moral values and material interests which does not guarantee a comprehensive realization of social rights, but which allows some progress in the fight against poverty-related diseases – a precondition of the possible further realization of social rights.

Key Words: Global Health Governance; New Governance Modes, International Organizations; Social Rights; Global Social Justice; Developing Countries; HIV/AIDS Politics

JEL Classification: F 35; I 18; I 19; I 39

Prof. Dr. Wolfgang Hein
is head of the research unit "Transformation in the Process of Globalization" at the German Overseas Institute and teaches at the University of Hamburg.
Contact: hein@duei.de · Website: http://www.duei.de/iaue/hein

Dr. Lars Kohlmorgen
is Research Fellow at the German Overseas Institute and teaches at the University of Hamburg.
Contact: kohlmorgen@duei.de · Website: http://www.duei.de/ghg/kohlmorgen

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Zusammenfassung

Global Health Governance: Konflikte um globale soziale Rechte

Dieses Papier untersucht, ob neue institutionelle Strukturen der Global Health Governance die Umsetzung sozialer Rechte in armen Ländern fördern. Gesundheit wird inzwischen vielfach als wichtige Voraussetzung für soziale und ökonomische Entwicklung angesehen, so dass-die Bekämpfung von Infektionskrankheiten inzwischen Bestandteil der Armutsbekämpfungsstrategien ist. Am Beispiel der globalen HIV-/AIDS-Politik wird analysiert, dass neue Governance-Formen zivilgesellschaftliche Gruppen und Betroffene einbeziehen, gleichzeitig aber auch von mächtigen Akteuren für deren eigene Interessen funktionalisiert werden können. Insgesamt werden erheblich mehr Ressourcen für die Bekämpfung der Krankheit zur Verfügung gestellt. Vor diesem Hintergrund kommt das Papier zu dem Schluss, dass Global Health Governance durch eine Kombination von moralischen Werten und materiellen Interessen gekennzeichnet ist, was keine umfassenden sozialen Rechte in den ärmeren Ländern garantiert, aber Fortschritte in der Bekämpfung von Krankheiten bewirkt – eine Voraussetzung für die mögliche weitere Umsetzung von sozialen Rechten.

Article Outline

1. Introduction
2. Globalization, Social Rights and Health
3. The TRIPS Agreement and Access to Medicines
4. Mobilization of Resources for Global Health: Old and New Actors in Global Health Governance
5. Conclusion: Current Form of Global Health Governance as a Patchwork of Compromises

1. Introduction

Article 25 of the Universal Declaration of Human Rights states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." This right was reinforced by Art. 12 of the International Covenant on Economic, Social and Cultural Rights, a legally binding instrument concluded in 1966 and ratified by all OECD countries with the exception of the USA. International discussions in the 1970s about a new international economic order and the World Bank's basic needs strategy focused at least partially on the needs to help developing countries to meet the duties taken over with this covenant.

At present, the importance given to the Millennium Development Goals (MDGs) indicates that the international community accepts the fact that we are far from being able to guarantee the social and economic rights laid down in these documents. Three developments can be seen as the cornerstones that characterize the problems and chances for progress:

1. The consolidation of an extensive body of contracts defining the rules of the international economic system with the aim of laying the base for a liberalized global economy.
2. A revival of the concern for social and economic rights as a reaction to the growing inequality accompanying the process of economic globalization. The latter has increased the capacity of worldwide material production, but also globalized communication and social interactions, increasing the awareness of the scandal of widespread poverty and poverty-related illnesses. We find a renewed and strengthened

concern for global social justice, on the intellectual level as well as on the level of global civil society activities (advocacy movements). These new actors – in particular NGOs – gained more importance in global politics due to a lack of regulation by 'traditional' international organizations and nation states at the global level.

3. International governmental organizations as well as OECD governments are – since the mid-1990s – are prioritizing strategies to fight poverty and to improve health strategies in poor countries and are more and more positively reacting to human-rights based policy approaches. The support given to the MDGs might be interpreted as a confirmation of this priority.

Can we see these developments as indications for a greater cohesion of a truly global society? In this paper we will look at the rise of global health governance as a form of institutional change reacting to new challenges: These consist primarily in changing conditions to improve access to health services related of a densification of social interactions in world society and the development of a global polity.

Analyzing the field of global health, we observe several conflicts and a constellation of actors whose positions on social rights can be summarized as follows: NGOs, welfare oriented international organizations like WHO and the World Bank (at least with respect to health and poverty reduction), some governments from developing countries and also industrialized countries press to realize social rights while powerful actors like other governments from industrialized countries hesitate or are shaped by certain national interests. Furthermore, pharmaceutical companies pursue their interests to sustain and even to extend a liberal global economic order.

Based on these observations we suggest the following propositions:

- The new institutional configuration of an evolving global health governance structure (like networks and partnerships between different types of actors) functions as a mode of integration and building compromises at the global level. Social rights are moving to the forefront as formerly weak actors and new actors pursuing social rights are strengthened.
- These new governance modes, however, can also be used by powerful actors (like nation states, transnational corporations) to pursue their interests; therefore policies for strengthening global social rights have to be pursued in an increasingly complex global polity.
- At the same time many UN organizations – the entities to guarantee global social rights in the post World War II international system – are weakened through the activities of new forms of political networks and non-complying nation states.

- The realization of global social rights in the field of health is more advanced than in other policy fields; but it is fragile due to the existing fragile and fragmented governance structures.
- Global health governance is a typical product of the combination of moral values and material interests that characterize the development of political institutions in an integrating social system. This can be observed as the core of historical nation building in today's industrial societies. It accompanies in a similar way the densification of social interactions on the global scale, the development of a global society.

We will discuss these propositions (1) starting with a few basic reflections on health-related codified human rights in relation to the concept of "equity" by Otfried Höffe (2002) and (2) summarizing the new challenges posed by globalization to global health. Following this, we will look at the conflicts characterized on the one hand by motives to support global health based on (a) the acceptance of the human right to health, (b) interests to support health as a global public good and (c) interests to support health because it is a basic precondition to other goals in regions typically characterized by poor health (poverty reduction, economic growth, security). On the other hand conflicts are shaped by interests not necessarily supportive of an improvement in global health (other uses of resources, economic liberalization, in particular globalization of rules for intellectual property rights).

In this context we will characterize (3) the new institutional developments in global health governance and demonstrate this more closely with respect to the problem of access to medication in the context of HIV/AIDS. We (4) consider as examples global trade rules and health (basically: conflicts around TRIPS, the agreement on Trade-Related Intellectual Property Rights) and (5) the increases of funds and changing types of actors in this field of global health governance.

2. Globalization, Social Rights and Health

Global Social Rights, Social Justice and Health

Frequently, the human rights discussion (including global social rights) and the philosophical discourse on social justice (or equity) are treated as one single issue which is, as we will briefly outline, not correct. Nevertheless, we will see that if respect to the basic problems of health both discourses will arrive at a similar point, i.e. that on the one hand, saving life is a basic element of social justice (and the access to life-saving treatment a basic human right). However we will also see that on the other hand, due to the ever more sophisticated and

expensive means of modern medicine, this also constitutes a fundamental economic and political problem.

In the introduction we referred to the role of health in international human rights documents. Thus, in the International Covenant on Economic, Social and Cultural Rights all "States Parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health " (Art. 12.1), which includes "The prevention, treatment and control of epidemic, endemic, occupational and other diseases" as well as "the creation of conditions which would assure to all medical service and medical attention in the event of sickness" (Art. 12.2). These documents, however, are rather inconclusive with respect to the "standard of health" which is supposed to be "attainable". In 2000 the Committee on Economic, Social and Cultural Rights (CESCR, a sub-committee of ECOSOC) adopted a 20-page document on "The right to the highest attainable standard of health"[1], stating (§ 47):

> "If resource constraints renter it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable."

Now, § 43 obliges State parties "…to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs" and "to ensure equitable distribution of all health facilities, goods and services". As drugs for an anti-retroviral therapy are on the WHO Essential Drugs List, States are formally obliged to provide this therapy to HIV/AIDS patients, but many sub-Saharan African states (with per capita public annual health expenditures of between US$ 0,10 and 0,20) are certainly not in a position to fulfill an obligation like this. States, however, also have the obligation to assist other states in fully realizing the right to health (§ 39):

> "States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health."

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[1] This document is part of a series of comments by the CESCR called "Substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights" adopted since 1989, here "General Comment No. 14" (document E/C.12/2000/4), accessible under the following URL: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument.

And finally § 64 reads:

> "Moreover, coordinated efforts for the realization of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society. In conformity with articles 22 and 23 of the Covenant, WHO, The International Labour Organization, the United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Band, regional development banks, the International Monetary Fund, the World Trade Organization, and other relevant bodies within the United Nations system, should cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates."

This is a typical example of "soft international law", which corresponds to abstract principles of basic human rights but certainly also is far away from constituting an enforceable obligation.

When dealing with the topic of global equity modern social philosophy more explicitly takes into account that we are living in a very diversified, unequal world in which (a) human beings are born into situations which give them specific entitlements and opportunities and (b) which constitutes the base for socio-economic reproduction. More equity cannot be attained by simple redistributions which might destroy the foundations also for an improvement of the situation of the poor. Therefore, in his "principle of difference" John Rawls defines "justice" in a very cautious way: it has to be ensured that in any change in a system the lot of the least advantaged individuals is also improved (cf. Rawls 1971: 78). This is taking into account the principle of "equal liberty": "Each person is to have an equal right to the most extensive liberty compatible with similar liberty for others.

Also Otfried Höffe (2002), who wrote the probably most influential recent German book on this topic (Democracy in the Age of Globalisation, 2002), takes the principle of liberty as a starting-point and sees the need to the control of force (violence) as the foundation of any legal and political order. He distinguishes negative rights of freedom (integrity of the body, freedom of opinion and religion etc.) from positive rights (social rights: health, education etc. which expand the potential uses of the freedom to act) which, however, include a broad spectrum of possibilities which human communities can fill in different ways, dependent upon cultural differences and a different level of resources, they are not absolute but comparative in character. In fact, this has to be accepted for many specific aspects included in the Covenant on Economic, Social and Cultural Rights (e.g. right to vacations, specific labor conditions etc.).

Basically, this also holds for the organization of the health system. There is, however, a basic problem with respect to health: As Höffe stresses, the foundation of all human rights is the ability of a person to act; the fulfillment of specific basic needs constitute a precondition for

all other aspects of social equity (Höffe) and therefore is not negotiable – "life" and thus also "health" certainly also have to be seen as the base of all other human rights. The supply of health services, however, consumes resources, and with the development of expensive medicines, medical appliances and forms of treatment, at least many countries, but probably world society as a whole do not dispose of sufficient resources to apply the most advanced forms of treatment to everybody. Certainly, it is not a human rights problem (though to some degree one of equity), if people cannot afford to own a car, but it is one, if they cannot afford life-saving treatment which upholds their ability to act.

In a historical situation of less extended and less intensive social communication and interaction and rather limited medical possibilities, the ethics of controlling infectious diseases was basically related to the form of quarantine measures in port cities. The potential for powerful health interventions, however, increased in close correlation with economic and communicative globalization; therefore we will have to look at the interrelated changes in at least four dimensions: capacity of health interventions, globalization of communication and claims for access to medicines, the globalization of health problems in itself and, finally, the impact of health problems in poor regions on other fields of global development.

Globalization and Health

In fact, we can identify a number of aspects which indicate that during the process of neoliberal globalization health has increasingly become an important global issue:

- We observe a more rapid spread of health problems, as a consequence of an expanding worldwide mobility (infectious diseases) as well as through the spread of consumption habits by global advertising etc. (smoking, changing patterns of food consumption). HIV/AIDS is seen as a global threat comparable to epidemics like pest and cholera until the 19th century, and new, so far unknown diseases like Ebola and SARS are interpreted as examples of new global challenges to health care.
- A very disturbing problem constitutes the fact that the defense mechanisms of antibiotics are weakening – because of an over-use by middle- and upper classes and an underutilization by the poorer segments of the population. The vicious circle of poverty and poor health might in fact extent its impact to medical treatment in the rich countries.
- The more rapid spread of drugs and medical technology from rich countries – in principle – to all corners of the earth has the potential to improve global health in general, but also leads increasingly to ethical problems as it makes the selectivity of health services related to income more and more obvious.

- The liberalization and global regulation of trade decreases the control of national societies over the production of medical drugs, health equipment and – with the General Agreement on Trade in Services (GATS) – to some degree as well over the supply of health services (cf. WHO/WTO 2002; Koivusalo 2003).
- There is an increasing concern for the vicious circle of rising poverty and growing vulnerability to health problems in large parts of what is becoming more and more a "global society". Social exclusion has become a problem of health and a starting-point for the spread of epidemics beyond the limits of slums and marginalized societies as well as a serious problem for the provision of health-related services itself. (cf. e.g. Dìaz-Bonilla et al. 2003).
- Governments of OECD-countries show growing concerns both because of this increased transborder spread of health problems and infectious diseases and because of the possible political and economic instabilities as a consequence of the high prevalence of poverty related diseases (like HIV/AIDS in some world regions). These concerns lead to increased global/international activities, which foster the process of political globalization.

A "healthy society" with a low incidence of infectious diseases (and, in fact, also a high consciousness with respect to the needs to prevent chronical diseases) can be considered a public good as no one – at least within a territory with free mobility – can be excluded from enjoying this good and there also is no rivalry in consumption. Health is increasingly considered a "*global* public good" as diseases and the resistance of pathogenous agents to antibiotics are ever more difficult to control within a local or national area, the development of effective drugs is basically part of a global market and, furthermore, improving health is a precondition for reducing poverty as a global phenomenon (see Chen/Evans/Cash 1999, Mills 2001). This implies that material interests of the "rich" concerning global health are by far exceeding health risks as such and also include many other aspects of the development of global society from which they cannot isolate themselves (e.g. political instability and insecurity, economic crises etc.)

These observations point to some structural similarities with the complicated historical process of the development of a social responsibility for public health in western countries: Moral obligations based in religious duties combined with practices of a spatial exclusion of infected persons (e.g. in the case of Lepra) were – in the process of an increasing density of social interactions – successively substituted by the acceptance of public obligations expressed in an extension of state functions related to societal integration (markets, administration etc.), but also accompanied by changing social norms with respect to health.

In effect, it was the spread of infectious diseases, which constituted the driving force for the development of some kind of international health governance in the 19th century (International Sanitary Conferences etc., cf. Labisch 2003). Now, the area of concern is expanding really to the globe as a consequence of the intensified interconnectedness of global society, which also implies the links between health and other aspects of social development. "Welfare state policies" at least with respect to health are becoming a global concern while in the same time “global market-creating policies” (Scharpf 2001) are reducing the control individual nation states have over the production of health sector inputs - thus changing considerably the framework for the development of health systems in developing countries.

The process of globalization, thus, strengthens the character of health as a global public good and as a consequence, in principle increases the concern of people in “rich countries” for the health situation in poor regions. “Health” becomes part of increasingly dense social relations and as such an ethical as well a material issue. Nevertheless, politics to react to this concern imply conflicts in different political fields:

- Preventing the spread of diseases: Restrictions on travel and the exchange of goods, cooperation in surveillance and research in emergency situations need to be internationally coordinated. The *International Health Regulations*, actually renegotiated through the WHO, serve as a means for that. As this implies basically emergency regulations which only marginally touch basic social rights to health we will not go into details.
- A more fundamental conflict has arisen around some aspects of the global trade system: The high prices of patent-protected drugs to suppress the symptoms of HIV/AIDS have prevented many poor countries from offering effective treatment to most patients in their countries. This as well as the fact that little money has been spent on R&D for effective drugs against tropical diseases has nurtured doubts about the adequacy about a patent- and profit-based system of pharmaceutical production for improving health conditions in developing countries.
- There is hardly any disagreement about the need for a significant increase of the financial transfers towards poor regions in order to improve their health systems as a precondition for local poverty reduction and for improving global health in general. On the other hand, the existing mechanisms for global financial transfers have proven utterly inappropriate for approaching the goals basically accepted.
- The huge gap between the needs for achieving a significant improvement of global health necessary from perspectives of global rights to health as well as of health as a global public good and the results attained within the system of international governmental institutions as it has developed after World War II, is certainly one of the

factors which has led to the development of a new institutional structure in the *Global Governance of Health* (cf. Dodgson et al. 2002; Lee et al. 2002; Hein/Kohlmorgen 2003). Before we turn to a more detailed analysis of the issues referred to above, we would like to explain our understanding of global governance and global health governance respectively.

Global Health Governance: New Actors and Institutions

Political globalization is not only a parallel process to the development of a new spatial order, but also an expression of a new configuration of actors, which is summarized by the term governance. Governance includes regulation by state (nation states, intergovernmental organizations), by self organization (private sector and civil society) and by networks (cooperation by states/international organizations, private sector and/or civil society). Modifying a definition by Renate Mayntz (2005) we can speak of global health governance as the totality of collective regulations to deal with international and transnational interdependence problems in health (cf. Bartsch/Kohlmorgen 2005).

While the greater importance of non-state actors (like NGOs and companies) is a general characteristic of politics in the era of globalization, non-state actors play in many regards a more important role in the health sector than in other sectors. We can say that there is hardly any other field of global politics where new institutional forms have gained a similar importance as in global public health. One general reason for this is the historical tradition of non-state actors' involvement in health affairs. Moreover, the role of new actors and institutions refers to the political weight of global civil society which has become particularly clear in the conflicts around the TRIPS agreement and the access to treatment for millions of HIV/AIDS patients. Furthermore there is a particular prominence of non-traditional mechanisms to raise resources for ends otherwise obviously underfinanced: e.g. the development of a whole system of global public-private partnerships GPPPs (there are about 100 GPPPs raising resources to support the development of new medicines and vaccines, to ease access to existing ones and to strengthen health services etc. (cf. Widdus 2001) and the rising role of private foundations indicate these new mechanisms.

This new institutional setting has an impact on the right to health particularly in poor regions. We already mentioned the vicious circle of poverty and health problems in many developing countries. This problem is most obvious in the case of HIV/AIDS in Sub-Sahara Africa, where some countries have a prevalence of sometimes more than 30 % of the adult population (aged between 15 and 49). The high prevalence rates in sub-Saharan countries cause a loss of economic growth, a weakening of human capital and, consequently, lead to a persistence of poverty as well as to political instabilities (UNAIDS 2004: 30 et seq.; Kohl-

morgen 2004). As most of the heavily affected countries have only scarce financial resources and often inappropriate state structures, they rely on international help and support in the fight against HIV/AIDS. As already mentioned, the self-interests of rich countries (threat of trans-border spread of infectious diseases, concerns about political and military instabilities) play an increasing role, which results in many activities by governments of rich countries, international organizations, NGOs and foundations to improve the situation of the poor. Global activities and their effects, however, are not restricted to poor countries. Even if middle-income countries like South Africa and Brazil do not rely on a large share of international help to finance their health systems, their HIV/AIDS politics are affected by global processes (see above).

Thus, the fight against HIV/AIDS and especially the activities in improving access to treatment constitute a highly virulent field of global health governance. In the following two chapters, we describe and analyze the conflicts on social rights in the context of a new configuration of actors by focusing on the two most important prerequisites of access to medicines in poor countries: a) The trade rules and international patent laws, which have a great impact on the procurement of affordable drugs especially in developing countries; and b) the raising of funds for financing medication and health systems and the provision of other resources in terms of knowledge and qualified personnel.

We will look at these processes taking up the arguments developed above: The dynamics of a densification of global social relations is expected to be reflected in an increasing importance of health as a global public good and a denser institutional system of global health governance. This again directs our attention to an intermeshing of changing material interests with an increasing acceptance of (and support for) global social rights.

3. The TRIPS Agreement and Access to Medicines

In the second half of the 1990s, drugs were available (and widely used in the industrialized countries) which transformed HIV/AIDS into a chronic disease; a combination therapy consisting of three different anti-retroviral drugs allowed most AIDS patients to lead a rather normal life – provided they did not develop resistances or strong by-effects against these drugs and they (or their health insurances or national health systems) were ready to pay about US$ 8.000-10.000 a year for the drugs alone. This was not due to the production costs of the drugs but to the exploitation of patent production by pharmaceutical companies which in this way were able to recover the high costs they spent on developing the drugs.

Meanwhile, in certain countries companies could (legally) produce the same drugs as generics for a fraction of these costs[2].

For the first time we encountered a situation where in the case of a disease which has been in the center of global attention for some time, effective forms of treatment were available but not accessible for the majority of people in need for them – due to lack of resources or due to extremely high prices. This differentiation is not as trivial as it might seem as it makes the difference between modifying the TRIPS agreement or developing means to compensate for the high costs, as neither the moral arguments to allow poor people access to medication, nor the political importance of fighting the AIDS pandemic in poor regions were irrefutable. The fact that some countries – like India – could offer cheaper drugs due to specific circumstances (cf. note 3) made the situation even more untenable. We will deal with this field of conflicts in three sub-sections: (a) The TRIPS agreement and the improvement of access to medication through a consequent use of its safeguards and the additional negotiations, (b) the advocatory role of NGOs in mobilizing support for an "adjustment" of TRIPS, and (c) Global Public-Private Partnerships (GPPPs) as initiatives which give the pharmaceutical industry an opportunity to express corporate responsibility and to defend patent protection at the same time.

TRIPS and Social Rights

The TRIPS agreement is part of a liberal global economic order comprehensively codified in the package of WTO agreements adopted in Marrakech in 1994. Clearly, the agreements are not meant to be Human Rights documents and therefore demands to include social (as well as environmental) clauses had from the very beginning hardly any chance to be realized. Neither, however, did WTO negotiators intend to express their contempt for human rights – particularly as they were continuously reminded of the risks to human rights inherent in economic liberalization. Certainly for a long time, they did not take criticisms by NGOs particularly serious, but various UN organizations did as well voice their concerns.

In effect, we find in all the agreements some general clauses that refer implicitly of explicitly to social rights and/or to the aim of development in general. The preamble to the "Agreement establishing the World Trade Organization" begins as follows:

> "The *Parties* to this Agreement,
> *Recognizing* that their relations in the field of trade and economic endeavour should be conducted with a view to raising standards of living, ensuring full employment and a

[2] This was due to the provision of the TRIPS agreement that developing countries which had already enacted an own system of patent protection do not have to adjust them to TRIPS rules until 2005, which was the case for India.

> large and steadily growing volume of real income and effective demand, and expanding the production of and trade in goods and services while allowing for the optimal use of the world's resources in accordance with the objective of sustainable development, seeking both to protect and preserve the environment and enhance the means for doing so in a manner consistent with their respective needs and concerns at different levels of economic development."

We find more concrete references to public health in Art. 8,1 of the TRIPS agreement:

> "Members may, in formulating or amending their laws and regulations, adopt measures necessary to protect public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development, provided that such measures are consistent with the provisions of this Agreement."

Similar references can be found in various other agreements[3]. Certainly these issues do not constitute the central targets of the trade agreements, but they constitute normative points of reference which can serve as a point for interpreting and re-adjusting provisions of the agreements[4]– depending of course on relations of interests and power in global politics. Certainly, the interpretation of these references is limited by the general aims of the agreements of which they form part (i.e. liberalization of international economic relations), and a theoretical construction that postulates a fundamental incompatibility between liberalization and human rights cannot but reject the WTO as a whole. On the other hand, the defense of agricultural protectionism in the context of WTO is a proof of the central role of power relations in the concrete working of the agreements.

Now, what has happened to the issue of TRIPS and access to medication? Since the end-1990s conflicts between the supporters of TRIPS and political strategies to improve access to the available anti-retroviral therapies had arisen in Brazil and South Africa and had rapidly attracted global attention. Both countries were not in the lucky situation of India, which had a local patent law – which only protected production processes but not specific products,

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3 Cf. e.g. GATS, Art. 14 b; preambles of the Agreements on Agriculture and on the Application of Sanitary and Phytosanitary Measures.

4 The first WTO Renato Ruggiero said 1997 in an address to a conference on "Globalisation as a Challenge for German Business": "But the real significance of the WTO's successes goes beyond the expansion of world trade - critically important though this is. Our ability to move towards the construction of a truly global system for an increasing globalized economy stands as a powerful and encouraging symbol for those seeking solutions to the many other issues which now spill across borders, jurisdictions, and cultures. Whether we are talking about the environment, development, labour, human rights or other ethical values - in all these areas there are positive signs that the policy debate is moving beyond the sterile divisions and polarities of the past. The search, instead, is for a more coherent global approach which balances the needs of the planet with the needs of the bns of people who deserve a better standard of living" (http://www.wto.org/english/news_e/sprr_e/bonn_e.htm).

but gave India ten years' time to adjust it to the TRIPS rules while Brazil and South Africa had to produce a new law compatible with TRIPS until 1997.

The Brazilian law authorized compulsory licenses in the case of national health emergencies which (a) was in line with TRIPS and (b) was only used as an instrument of pressure in the negotiations with pharmaceutical companies to reach better terms of licensing to Brazilian companies and to reduce the prices of drugs in Brazil. A WTO panel dispute, however, was initiated by the US against the so-called *local working* requirement of the law: If a foreign license-owner does not establish local production within three years, the government is authorized to license local production. Though the US complaint had a solid base, the US withdrew the complaint in June 2001 as Brazil indicated that it would only use the law in the case of pharmaceutical products (cf. Calcagnotto/Wogart 2004; Wade 2003: 5 et seq). This move can already be interpreted as a reaction to the mounting public pressure to improve access to ARVs for treating AIDS patients, particularly since the Brazilian AIDS programme has been internationally praised for its success.

In South Africa, the Pharmaceutical Manufacturers' Association of SA backed by 38 Pharma TNCs filed a lawsuit in 1999 against the South African Government which had authorized in 1997 the use of parallel imports to lower the costs of AIDS treatment (Medicines and Related Substances Control Amendment Act); before that there was a threat from the US-congress to cut off all aid to South Africa. In April 2001, however, the lawsuit was dropped by the pharmaceuticals industry, as it proved to be a fiasco for their image.

Both conflicts had shown that public opinion had become mobilized against a politics of intellectual property rights which guarantees profits to TNCs while effectively denying treatment to those in need. Obviously, at least in an extremely mediatized situation, it seems that human rights prevailed over international economic regulations. The 4th Ministerial Conference of WTO at Doha in November 2001 proved to be the right forum for a showdown about the access question, in particular as – besides the high level of popular attention – the industrialized countries were interested in opening-up a new round of trade negotiations and, thus to prevent any antagonizing conflict with important developing countries. This situation favored the adoption of the so-called Doha Declaration on the TRIPS agreement and Public Health stating (§ 4):

> "We agree that the TRIPS Agreement does not and should prevent members from taking measures to protect public health. Accordingly, while reiterating out commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all. In this connection, we reaffirm the right of WTO members to use, to the full, the provisions in the TRIPS

> Agreement, which provide flexibility for this purpose“ (referring to the possible use of compulsory licenses and parallel importing).

One problem remained to be solved: Compulsory licensing was authorized basically for local consumption, which posed a problem for poor countries which had no industry in the position to produce generics. § 6 of the Doha Declaration stipulated further negotiations on the conditions of compulsory licenses for the supply from third countries. Conflicts prevailed on the interests of the pharmaceutical industry to restrict these regulations to a small number of diseases to make sure that exports to industrial countries could be prevented. Again, after one and a half years of negotiations the industry (basically represented by US negotiators) was only marginally successful. They had to accept the authorization of compulsory licenses in the case of health emergencies *irrespective of the disease involved*. The only concession was related to the obligation of producers to mark these products by a specific shape, color or packaging.

The (intermediate) result of the conflict led to a situation where the WTO secretariat found itself on the same side with civil society groups often seen as ”globalisation critics”, while the pharmaceutical industry grudgingly accepted the results. Certainly, it can be seen as a success for developing countries (in the context of an inter-national organization like WTO) and a global civil society in fight for global social rights (in the context of a densification of social relations in a global society). The role of NGOs in the fields of health and human rights as a powerful catalyst for mobilizing public opinion is obvious. However, the function of NGO activities is less obvious but may be not less important in its function to empower poor developing countries to take a strong position in the negations on § 6. The pharmaceutical industry was determined to prevent any softening of IPR rules, but they as well had to realize that a global economic order is not possible without an intensification of global social relations and the acceptance of global human rights. They had to demonstrate corporate responsibility, which they did by entering Global Public-Private Partnerships (see below chapter “Pharma TNCs and GPPPs: Accepting the Right to Health and Defending Corporate Interests”).

The outcome of the conflicts on TRIPS and access to drugs shows that in the case of a strong mobilization of global civil society the safeguards and general clauses included in the WTO agreements can in fact be used to prevent effects of these agreements that directly threaten human rights in the case to health. The negotiations on § 6 of the Doha Declaration showed that – in the case of strong political support – the institutional set-up of WTO/TRIPS is flexible enough to adjust the agreement in a way that makes it more responsive to particular human rights requirements in health.

We have to realize, however, that for the time being there is not enough political support to structurally empower developing countries through economic development and to strengthen their resource basis to broadly improve the so-called positive human rights in their countries. Robert Wade of the London School of Economics argues that while the (post-) Doha modifications of TRIPS might increase TRIPS-consistent options in a humanitarian direction (2003: 5 et seq.), this is not the case in the field of industrial transformation. When representatives of pharmaceutical TNCs stress the importance of patent protection as a pre-condition for investment and technology transfer they suppress the fact that more rigid patent right hampers the acquisition of technological skills by reverse-engineering, imitation etc. and will probably increase the already existing large gap between research-oriented TNCs (basically from the industrialized countries) and a local industry basically restricted to produce out-of-patent generics. Wade points to the central importance of these skills for the industrial development of countries like Japan, Taiwan, South Korea but also the U.S. in the 19th century, but:

> "…today, reverse-engineering, imitation, and many strategies of innovation to develop technology are either outlawed or made significantly more difficult by the high level of patent and copyright protection mandated by TRIPS. Thus, TRIPS raises significant development obstacles for many countries that the earlier developers did not face. These issues were not on the table at Doha." (Wade 2003: 5)

However limited, the Doha declaration and the § 6-negotiations demonstrated that – at least under certain conditions – it is possible to convert the references to more general norms of global equity in WTO agreements into concrete compromises to deal with situation of obvious injustice. Certainly, this has to be seen as part of a process of global socialization: A market-based global economic integration is only sustainable if it is supplemented by institutional developments which can deal with the social inequalities and conflicts which accompany economic globalization, i.e. if it permits the articulation between traditional and new social actors in new processes of shaping global rules and finding compromises to solve conflicts. Still, it has to be seen, how the §-6-solution will work if compulsory licenses will be used to ease access to medication in the case of other diseases or in the case of new generations of AIDS medicines. With respect to 1st line ARVs the losses for the industry through price reduction in the last five years do not seem to be that important: Patents of many first generation ARVs are already comparatively old; profits have been "harvested" and the patent owners reduced prices in order not to give an occasion for the use of compulsory licensing. What will happen in the case of new generation medicines (2nd line treatment etc.) remains to be seen. At any rate, NGOs and other civil society actors will closely watch the strategies of pharmaceutical companies.

The Role of NGOs and the Development of a Global Civil Society

Protests of NGOs and global social movements against GATT and the WTO and their schedules for international economic liberalization are not particularly new, and certainly they had an impact in creating political pressures on economic and political actors, in particular on those international organizations which had laid the institutional base of economic globalization (WTO, World Bank, IMF). Even though these social movements often have appeared as rather uncompromising opponents of globalization, they had an important impact on those international organizations (cf. e.g. O'Brien et al. 2000) and slowly began to change their character from basically mobilizing and advocatory actors towards cooperating experts and actors with a negotiating role in the global political process.

These non-state actors increasingly assume forms which resemble civil society structures on the national level: Civil society developed historically as an element of an open, self-organizing space beyond the hierarchical structures of the state, filling the public space which opened up with the decay of feudal institutions. In a similar way global civil society fills up a space which arises with the increase of transnational social relations beyond the nations states and the formal inter-national relations between them.

Global civil society can be seen as arising from the self-organization of social interests and concerns which have a pre-state character in a double sense: Like in a nation state, this refers to the construction of opinions, social norms, the expression of interests before these issues might become topics of formal politics, but it also refers to problems for the treatment of which there does not exist a formally competent political institution (e.g. for the implementation of global social rights). We witness the development of a complex field of civil society activities and structures which to some degree substitute non-existing state-structure. Their hybrid character is also expressed in the fact that they are more or less recognized as legitimate representatives of underprivileged groups in a particular political field (e.g. OXFAM and the MSF in health politics) and have an important impact on negotiations between representatives of states in another political field which has attained a higher degree of formal organization on the international level (trade/WTO).

The active role of global civil society in a process renegotiating WTO rules is an example of such a phenomenon – this refers in particular to the role of NGOs as advisors to developing country members of WTO[5]. They organize pressure on Northern states basically by influencing public opinion, which is a typical role of civil society. But they also more or less directly coordinate the political positions of Southern nation states, which otherwise would have

[5] The South Centre has played an important role in organizing communication between health NGOs and Southern national delegates to the WTO (interviews of the authors with representatives in Geneva on §-6-negotioations).

hardly any impact on WTO negotiations. In this way, NGOs assume an important role as some kind of midwives for the development of formal global politics. There also exists an increasing tendency for international organizations and bilateral aid agencies to channel aid – in particular aid in the health sector – via networks of NGOs: Examples for this are the Global HIV/AIDS Alliance, which, more like a QUANGO[6], was founded by official AID institutions of important industrialized countries, private foundations (Gates, Rockefeller foundation) and international organizations (WHO, UNDP, UNFPA), and TNCs to support local NGOs in fighting HIV/AIDS, but also the large number of frequently religious NGOs through which an important part of PEPFAR[7] money is channeled.

There does exist quite an important body of work on various aspects of NGOs as well as some work on CSOs in specific politic fields, but there still remains a lot to be done to better understand the role of civil society in the development of a global polity. For example, it is important to analyze civil society's role in the mobilization of public opinion and its catalytic role in the development of a system of global norms and in the implementation of global social rights through the impact of NGOs in the play of forces during the negotiations of international agreements and their role in monitoring them.[8]

Pharma TNCs and GPPPs: Accepting the Right to Health and Defending Corporate Interests

Intellectual property rights are the most important base for recovering the capital invested by pharmaceutical companies in research and development. A research project arrived at an estimate of US$ 802 Mio. for the development costs for a new medicine.[9] Even though these data are heavily debated, there are few doubts about the dimension of costs and risks involved. Therefore, it is not surprising that the industry is strongly opposed to any form of weakening the patent system even if they might accept that this system has its flaws with respect to linking research endeavors to the needs of the majority of world population (issue of "neglected diseases") and ensuring universal access to existing medicines. As the industry's headquarters and research centers are (not surprisingly) located in the most advanced industrial countries, it is also not surprising that these countries are basically strong sup-

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6 QUANGO stands for "Quasi Non-Governmental Organization".

7 The President's Emergency Plan for AIDS Relief; cf. chapter 4.

8 For a more detailed analysis on the development of global civil society and its relation to health: cf. Bartsch/Kohlmorgen 2005 und Hein 2005.

9 DiMasi/Hamsen/Grabowski (2003) analysed the R&D costs 68 randomly chosen drugs (of course on the basis of data provided by the pharmaceutical industry).

porters of TRIPS and the IPS system – though of course challenged by a strong position of civil society organizations at home and in global politics.

At the same time pharmaceutical companies cannot deny that the industry as a whole is highly profitable. Thus, the more the right to health is becoming a central political and moral issue, the more the industry is coming under pressure to come up to its corporate responsibility and to contribute itself to the fight for a "better health for all". In fact, from their perspective nothing seems to be better suited than a strategy of global public-private partnerships (GPPPs). In the first instance, GPPPs evolved since the end 1980s around the problem of developing new medicines and vaccines for the typical diseases of the poor and marginalized parts of the global population; it is said that approximately 10 % of all R&D resources are spent on the diseases which cause 90 % of the so-called "global burden of disease" ("costs" of a disease in term of deaths and disabilities). Through cooperation between relevant actors, normally international organizations (frequently WHO), pharmaceutical companies, sometimes private sponsors, costs and risks in R&D are shared and the access of poor people to the new drugs is guaranteed.[10]

Another type of GPPP concentrates on easing access to drugs which are already on the market. Earlier examples are the Mectizan Donation Programme (medicine ageist river blindness) and various other similar programmes (among others involving drugs against malaria). The most important programme in the case of HIV/AIDS is the Accelerating Access Initiative, a GPPP involving five UN agencies (UNAIDS, WHO, World Bank, UNICEF und UNFPA) and five pharmaceutical companies (Abbott Laboratories, Boehringer Ingelheim, Bristol-Myers Squibb, GSK, Gilead Sciences, Merck Co, and Hoffmann – LaRoche), working together with national governments. It is the largest such endeavor of the industry to cooperate in providing access to HIV-treatment. A document published in January 2005 stressed that that by September 2004 330,000 patients were treated with ARVs supplied by AAI companies, i.e. about half of all patients in developing countries receiving treatment by that date.

In addition to GPPPs, there are a number of other political initiatives in which the industry is involved like the Global Health Initiative of the Global Economic Forum (Davos) or the Global Compact initiated by Un General Secretary Kofi Annan in 1999. Many of the GPPPs have been criticized by civil society actors and often by public health specialists as well – for example for linking humanitarian actions to specific interests of the firms involved, for not offering reliable and transparent solutions to the problem of access and medical service. On the other hand, there is no doubt that the rise of GPPPs reflects the acceptance that pharma-

[10] Examples for this type of GPPPs are the Medicines for Malaria Venture, the Global Alliance for TB Drug Development, the International AIDS Vaccine Initiative and the Global Alliance on Vaccines and Immunization.

ceutical R&D and the access to patented drugs constitute a public issue to be negotiated. The role of GPPPs fits into the general picture of an increasing complexity of global health governance: Though it is difficult to assess "how these initiatives affect the health and the conditions of those they are meant to help" (Health Action International), they have constituted another field of activities characterized by a broad involvement of various types of actors in global health governance thus strengthening the general acceptance of a universal right to health.

4. Mobilization of Resources for Global Health: Old and New Actors in Global Health Governance

In the following we explore the relation between new institutional settings and the realization of social rights by describing and analyzing some actors of global health governance and four initiatives of improving the financing of the response to HIV/AIDS: the World Bank with its Multi Country HIV/AIDS Program (MAP), the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria, the World Health Organization with its 3 by 5 Initiative and the President's Emergency Plan for AIDS Relief (PEPFAR) of the U.S. Government. In the preceding chapter we focused on one side of the economic preconditions for access, the various factors having an impact on the prices of effective drugs. The following short summary on the rapid price reductions reached between 2000 and 2004, gives an idea on how much access has been eased. Now we have a situation, in which in many poor countries the transfer of international resources could at least open a window for starting treatment programs on a larger scale.

Reduced Prices, but More Resources Needed

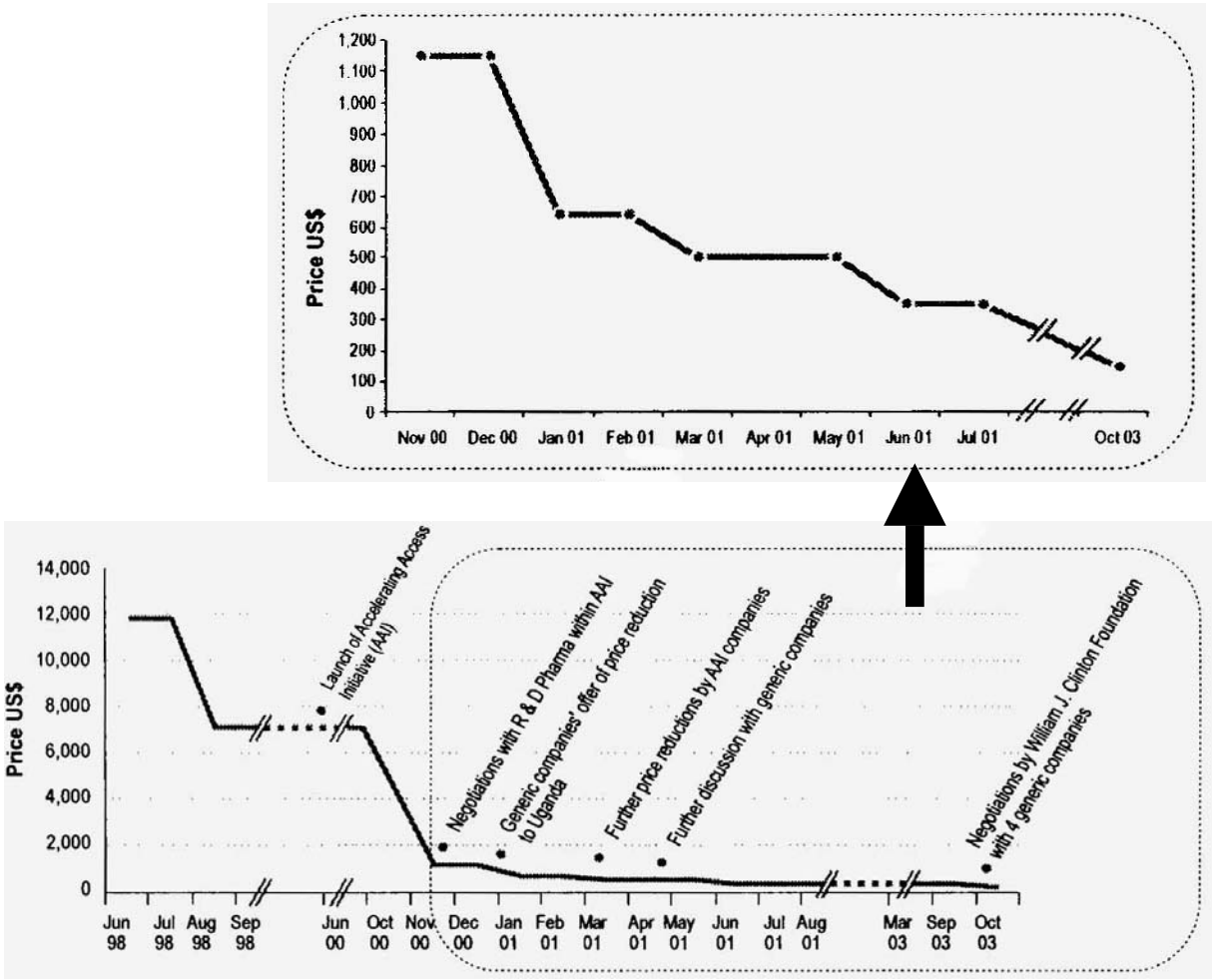
Since the late 1990s prices for antiretroviral (ARV) drugs in developing countries significantly decreased. Prices for ARV (typical triple therapy) fell e.g. in Uganda between June 2000 and the end of 2003 from US$ 12,000 to US$ 140 (per person/year). We can identify mainly three activities which caused this price decrease; two of them can be characterized as network regulation in the context of global health governance:

- Competition because of the market entry of generic producing companies especially in India can be seen as main reason for price reduction. In 2003 the lowest price for a branded drug was US$ 562 (per person/year), for generics US$ 237 .
- Within the Accelerating Access Initiative, launched for providing people suffering from AIDS with affordable drugs and for lowering prices of drugs (see above), nego-

tiations between the participating companies led to a price reduction towards US$ 700 to 1300 (depending on the concrete medicine; GlaxoSmithKline press release from April 7, 2001).

- The Clinton foundation, the World Bank, UNICEF and the Global Fund negotiated with generic producers in India on drug prices. The result was a reduction from US$ 237 to 140 (per person/year) for more than 100 developing countries.

Figure 1: Prices (US$/year) of a first-line antiretroviral regimen in Uganda: 1998-2003



Source: UNAIDS 2004.

This cut in prices can be seen as an effect of new institutional modes in global health governance. Moreover, it is an indicator for an improvement of social rights for AIDS victims. Although affording US$ 140 per year is still a problem for many AIDS victims in poor countries and a proper health system is necessary for the functioning of AIDS treatment, one prerequisite for the access to treatment, a substantial decrease of drug prices, has been achieved. In the following we will examine the activities and conflicts on the general precondition for

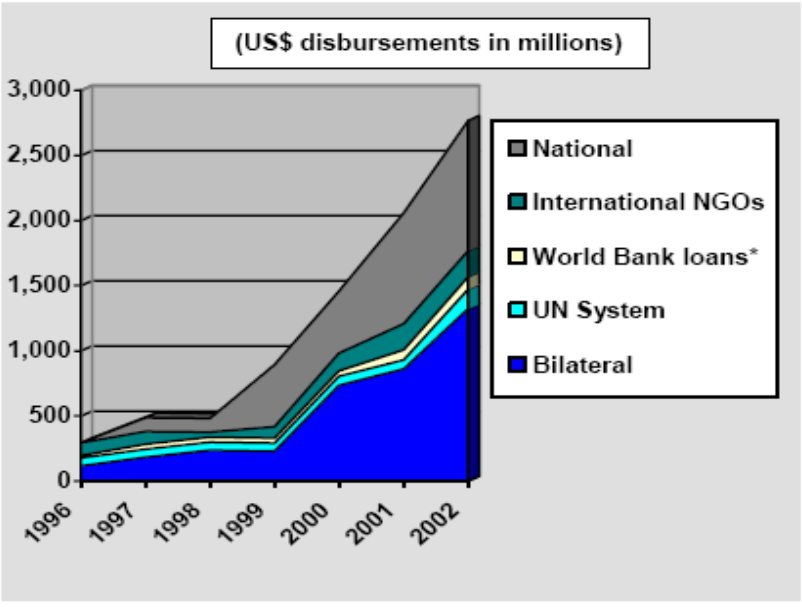
the fight against HIV/AIDS, the global funding of programmes and initiatives in poorer countries.

Mobilization of Resources and New Actors in Global Health Governance

Before we turn to specific organizations and their strategies let us have a short look at the trends of financial transfers (see figures 2 and 3 below). The figures of funding for the global fight against HIV/AIDS (excluding the financing in North America and Western Europe) indicate three trends:

- First, there is an significant increase in global spending for the fight against HIV/AIDS since the mid 1990s in total (including national and international funding) as well as in international funding alone (two-thirds are provided internationally). From 1996 to 2004 the money spent for the fight against HIV/AIDS increased from 250 mio. to 7 bn altogether.
- Second, it becomes obvious that governments of nation states (both donors and developing (recipient) countries) are by far the greatest funding source.
- Third, there is an increasing funding gap, an unmet need for greater funding to reverse the global HIV/AIDS pandemic. For 2005, e.g., about US$ 11 bn are needed, but only 7-8 bn are expected to be available.

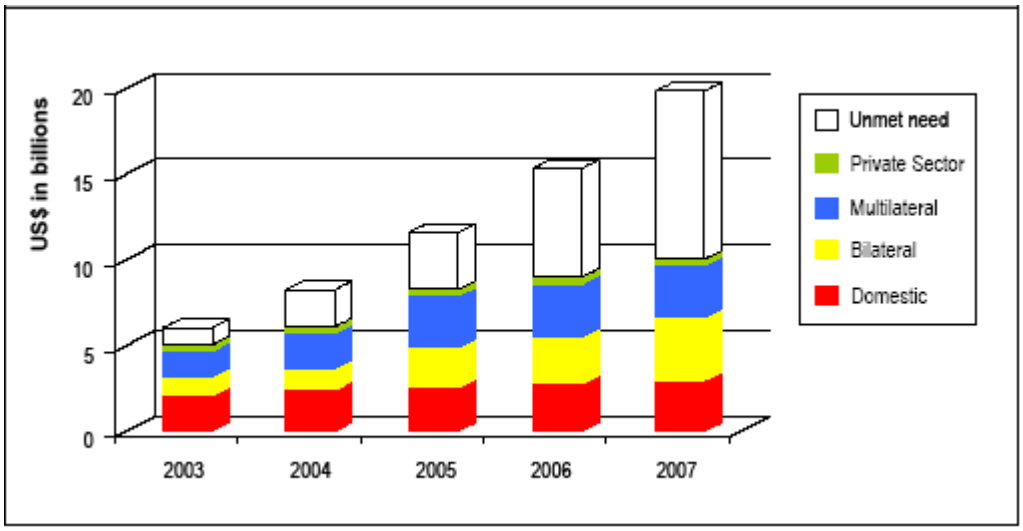
Figure 2: Global Spending for the Fight Against HIV/AIDS in Developing Countries (1996-2002)



*Grant component of concessional loan disbursements.

Source: UNAIDS 2003.

Figure 3: Projected Funding to Fight HIV/AIDS



Source: UNAIDS 2004.

Thus, on the one hand these figures show that global health governance improves the fight against HIV/AIDS and consequently the realization of social rights, on the other hand great funding problems are obvious. Furthermore, it is undeniable that nation states are still the most important actors in global health governance –a fact which is often neglected in most of the work on global governance. After stating this, let us now have a closer look at the main actors of global health governance and their funding activities.

The *World Bank* can be characterized as an actor which chiefly aims at social and economic development (and thus only indirectly at the realization of global social rights). The bank's first activities in the health sector started in the early 1970s, but first loans were not awarded until the 1980ies. The 1993 World Development Report "Investing in Health" (recommending a public-private mix for financing and organization of health systems) had a great conceptual influence on health system reforms in the 1990ies. Furthermore, the Bank had (and still has) a great impact on health policies due to structural adjustment policies that now turned into poverty reduction policies.

Since 2000, the World Bank runs the Multi Country HIV/AIDS Program (MAP). 26 African countries have received more than US$ 1 bn so far. Participation of non-state actors at the country level and good governance are prerequisites for recipient countries to receive money in the MAP. Thus, although the MAP is a program by an international organization it empowers non-state actors at the national level and relies on networking.

The Bank is the greatest single donor in health and one of the greatest single donors in the fight against HIV/AIDS. As providing funds and resources means having power, the Bank is a powerful actor. But it is not only powerful because of its lending and granting activities but also because of its discursive power in influencing political and operational strategies in

the health sector. Some say that since the 1990s the World Bank is the most powerful organization of global health governance (cf. Abasi 1999; Buse/Gwin 1998: 666; Lee et al. 1996; Thomas/Weber 2004: 194).

The *Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria* is the greatest single funding organization in the fight against HIV/AIDS. It is often regarded as a global public-private partnership (GPPP), which in a sense is true, but the following sketch will show that it differs from "typical" GPPPs. (for GPPPs in health: see above and Bartsch 2003; Buse/Walt 2002; Richter 2004). But there is one similarity: The Global Fund as well as other PPPs tackle specific diseases instead of aiming at comprehensive health provision.

The Global Fund can be characterized as a multilateral funding mechanism that works like a partnership. It was launched in 2002 and has attracted financial commitments of US$ 6 bn so far (February 2005).[11] 94.4 % of the money donated is provided by OECD members, 1.1 % by non-OECD countries. A closer look at the 4,5 % private and civil society donations shows that the Bill and Melinda Gates Foundation – generally one of the greatest financer of global health activities – alone is responsible for 97 % of all non-state donations. Corporations contributed only 0,06 % of all donations.[12] Thus, the Global Fund hardly generate any financial resources from new and unconventional sources (like private funding), it just has a new and – compared with international governmental organizations – unconventional governance structure: Nation states (seven from each the North and the South), NGOs (3), foundations (1) and companies (1) are voting members of the Executive Board. The World Health Organization, World Bank and the Joint United Nations HIV/AIDS Programme (UNAIDS) are only non-voting members. Recipient countries have to create a Country Coordinating Mechanism with participation of all stakeholders (including civil society and private sector) that is authorized to apply for funds to conduct programmes.

The Global Fund was initiated at Kofi Annan's suggestion with assistance of the G8 countries. It was launched as a finance mechanism separated from the UN and the WHO, because especially the USA, but also Japan and Italy did not want to have it under the auspices of the UN. This, of course, led to controversial discussions, because UN organizations and especially the WHO feared a loss of influence on global health issues and some health experts and NGOs were afraid of a privatization of governance.[13]

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[11] US$ 3 bn have been donated already, US$ 2 bn have been granted to projects and programmes in recipient countries, US$ 900 mio. have been disbursed so far. 56 % of these funds are provided for HIV/AIDS measures like prevention and treatment.

[12] For data see: http://www.theglobalfund.org/en/files/pledges&contributions.xls (18-Feb-05).

[13] There are still positions inside the WHO, UNAIDS and the World Bank that the separate structure of the Global Fund is a mistake, but many staff members now accept this separation or even think that it is an advantage for funding and disbursing money to fight diseases (source: more than 30

This separate construction of the Global Fund is an interesting point if we look at the interests and strategies of powerful nation states and if we bear in mind propositions on the relative loss of (nation) state power: Nation states (like in this case mainly the USA) use network regulation (the Global Fund) to circumvent international organizations (the WHO). This means that networks, which lead to a sharing of the states' power and influence with other actors, are a result of the nations states interests. The Global Funds' separate structure also implies that in the case of allocating money overwhelmingly given by nation states to fulfill a global public task a formally legitimized UN organization like the WHO is sidestepped by a new form of organization (legally a Swiss-based foundation). But at the same time the partnership structure of the Fund involves actors fighting for social rights like NGOs and also organizations of people living with HIV/AIDS.

The *World Health Organization* was founded by the members of the international community "for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples" (WHO Constitution). Therefore, it is *the* organization of nation states to promote global health, and the delegates of member states decide on the organization's strategies and policies in the World Health Assembly (WHA). The WHO is an actor that aims at the realization of social right in the field of health. 'Health for All' is not only the aim of the WHO as an organization but it is also established as the central objective of international and national health activities by the nation states throughout the world. The International Conference on Primary Health Care in Alma Ata in 1978 proposed and the World Health Assembly in 1979 endorsed Primary Health Care as strategy to achieve the objective of "Health for All by the Year 2000", not by just giving the poor a minimum of health services (in a more liberal sense), but by providing health services for all a foundation of a comprehensive health system (in a universalistic sense). The Declaration of Alma Ata concretizes the announcement of health as a fundamental human right in the Covenant on Economic, Social and Cultural Rights:

> "The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."

The main responsibility in fulfilling these obligation is ascribed to the national governments, yet the international organizations and the world community are also committed to achieve

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interviews with experts and with staff members of WHO, World Bank and UNAIDS conducted for the research project 'Global Health Governance' at the German Overseas Institute.)

a level of health for all people "that will permit them to lead a socially and economically productive life" by the year 2000 (Declaration of Alma Ata 1978, WHO 1978).

Due to a hegemony of neoliberal concepts in the broader field of global economy which influenced also health politics and due to the influential assumption that the Alma Ata concept of Primary Health Care was too idealistic and not feasible, in the 1980s the concept of Selective Primary Health Care became dominant in discourses and in health activities. This strategy focused on specific diseases in developing countries and on the lack of immunization and defined so-called attainable goals. Some donors, international organizations and scholars favored this concept, and its influences reach to the current focus on fighting specific (mainly infectious) diseases. However, not only the hegemony of neoliberal concepts highlighting targeting, selective help and private provision instead of comprehensive health care provision, but also failures in developing countries in implementing this strategy have reduced the importance of the Primary Health Care approach in current global health policies[14], although it is still part of declarations and speeches and of the agenda of health policy objectives (Cueto 2004; Thomas/Walter 2004: 192 et seq.).

As we know, by 2000 the objective of Health for All was not attained, and the chances to reach it in the near future are not very good. Nevertheless, in 1998 the WHO (to be precise: the World Health Assembly) renewed this objective under the label of 'Health for All in 21st century' and declared that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" (WHO 1998). This commitment also announces that the availability of essentials of Primary Health Care should be ensured. Thus, the world community sticks again to the axiom that health is a fundamental human right.

The WHO is – especially since the 1990s – a relatively enervated actor of global health governance for at least four reasons:

- Like other UN organizations WHO acts relatively slowly because its activities depend on a decision-making process which has to aggregate the interests and commitments of member states and is therefore frequently complicated and slow. Many experts criticize the WHO as a too bureaucratic organization.
- As WHO fosters social rights and works for greater parts on behalf of the interests of developing countries, powerful actors from industrialized countries (which are at the same time the main donors of WHO) try to weaken and circumvent the WHO, if they perceive their own interests to be different.
- New actors at the global level (like NGOs and "big pharma") challenge the WHO.

[14] Nevertheless, countries like Cuba, Costa Rica and the Kerala region in India which are realising the Primary Health Care concept at least in some of its aspects show good results in health provision (e.g. low infant mortality), as e.g. the World Bank states (World Bank 2004).

- The WHO is not a funding organization (its main formal objectives are technical assistance and setting norms).

Besides its day-to-day activities we can identify two main strategies that were intended to enhance the WHO as an actor of global health governance. The first has been to foster PPPs under the aegis of Gro Harlem Brundtland (e.g. Stop TB and Roll Back Malaria are hosted by the WHO). These efforts can be interpreted as a reaction of the WHO to the changed institutional setting and as an attempt to regain power in this institutional change, which provides private actors with greater influence in politics.

The second strategic decision was the re-integration of politics and activities to fight HIV/AIDS into the WHO. After the establishment of UNAIDS in 1996 the WHO transferred its competences, personnel and resources in handling HIV/AIDS to this new joint venture of UN organizations[15]. The main objectives of UNAIDS are the coordination of UN activities and to advocate a global reaction against the HIV/AIDS pandemic. In spite of great problems in coordinating the UN member organizations, UNAIDS can be seen as the leading UN organization in the fight against HIV/AIDS as far as normative and strategic aspects are concerned, until the WHO started to develop its own HIV/AIDS policy again in 2000/2001. In 2003, the WHO (together with UNAIDS) launched the so called 3 by 5 Initiative which aims at providing 3 mio. people suffering from AIDS with ARV drugs until the end of 2005. Looking again at the realization of social rights, this is an interesting turn in WHO's policies which is accompanied by a general turn in global HIV/AIDS policies: While during the 1990s the WHO and other international organizations focused on prevention, now the treatment of AIDS patients – and consequently the implementation of social rights of AIDS victims – is in the foreground of the fight against HIV/AIDS and in the related discourses. This change in direction was influenced by Brazilian HIV/AIDS policies which emphasize treatment and by Brazil's National STD/AIDS program which provides people suffering form AIDS with

[15] Co-sponsors of UNAIDS are: United Nation Children's Fund (UNICEF), WHO, World Bank, Office of the United Nations High Commissioner for Refugees (UNHCR), World Food Programme (WFP), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), United Nations Educational, Scientific and Cultural Organization (UNESCO) and International Labour Organization (ILO). Delegates of NGOs and of groups of people living with HIV/AIDS are members of the Programme Coordinating Board. Although these NGOs are only non-voting members of this most important board of UNAIDS, their participation and also UNAIDS' encouragement of NGO involvement at the national level illustrate the importance of networks between public and private actors in global health governance (cf. Kohlmorgen 2004).

drugs free of charge (besides prevention activities). Thus national policies have affected global policies and have led to greater efforts to realize social rights at the global level.[16]

Regarding our thesis on the correlation of new institutional arrangements and the provision of social rights, we can observe that networks are essential in the pursuit of the objectives of 3 by 5. As the WHO is no funding organization it can only increase its budget for more activities in training health workers and developing health systems, but cannot close the estimated 3 by 5 funding gap of US$ 5,5 bn. The WHO cooperates with other organizations and initiatives like the Global Fund, PEPFAR and other bilateral initiatives and civil society actors like NGOs and foundations both at the global and at the national level. The WHO is reliant on other actors to implement 3 by 5.

Summing up, we can say that with the 3 by 5 Initiative the WHO tries to gain influence in global HIV/AIDS politics and in one of its most salient policy fields, the AIDS treatment, dominated by the Global Fund and bilateral programmes like PEPFAR. This can be interpreted in the context of organizational interests: The WHO has to play a more prominent role in this central field of global health governance in order to defend its claim to be the legitimately responsible institution for global public health. This also includes the motif to support the realization of social rights. The WHO demonstrates that it is capable of strengthening social rights to health by acting in the new institutional setting of global health governance (networks, greater role of private actors). However, at the same time the dependence on other actors in implementing the 3 by 5 Initiative shows the weakness of WHO (similar to other UN special agencies).

This necessity to cooperate leads to compromises between conflicting actors. E.g. 3 by 5 cooperates with the *President's Emergency Plan for AIDS Relief* (PEPFAR), although there are different political and strategic approaches and conflicts between the US government and the WHO on certain aspects of the fight against HIV/AIDS. PEPFAR has been launched in 2004 as a bilateral program providing US$ 15 bn until 2009 to fight HIV/AIDS (US$ 9 bn for new bilateral programmes in 14 African and Caribbean countries, 5 bn for existing programmes in 75 countries and 1 bn for the Global Fund). PEPFAR is directed by the US Global AIDS Coordinator, Randall L. Tobias (a former CEO of the pharmaceutical company

[16] However, there are also sceptical and critical comments on WHO's current strategy within the WHO and by experts outside the WHO: Some fear a disregard of other diseases (like e.g. malaria) and other health aspects; one expert wonders if it is the right decision to focus on just one disease; most experts fear a neglect of health system upgrading, which is not only necessary for AIDS treatment, but also for all other health problems (although all 3 by 5 documents stress the importance of health system development). (Source: interviews with experts staff members of WHO, World Bank and UNAIDS)

Eli Lilly & Co). It is implemented mainly by USAID, but with great involvement of US based NGOs and NGOs from the recipient countries.

PEPFAR propagates the ABC method of AIDS prevention: *A*bstinence, *b*e faithful in partner relationships and use *c*ondoms only as a last solution or for risk-groups (like prostitutes), which was first developed in Uganda. Besides prevention PEPFAR focuses on treatment. After the Office of the US Global AIDS Coordinator has been accused by NGOs for only financing branded drugs, now PEPFAR also utilizes generic drugs in some cases.[17] In 2004, a conflict arose on the approval process of drugs being used in developing countries, when the Office of the US Global AIDS Coordinator announced that it would use the approval process of the US Food and Drug Administration (FDA) instead of using the Prequalification Project. The Prequalification Project is a multilateral approval mechanism run by the WHO which tests the drugs (both generics and branded) procured by UN organizations and assists many developing countries in their drug approval process, as many have problems to finance their own fully equipped approval mechanism. Critics argued that the approval process of the FDA could refuse generics, not because of quality problems but because of political interests arising from the US pharmaceutical companies.

However, this assertion – of course – is difficult to prove, but this conflict – and the fact that PEPFAR is primarily a bilateral programme and does not allocate greater shares of financial resources to the Global Fund or to the 3 by 5 Initiative directly (although the WHO includes PEPFAR in 3 by 5) – show that the US government does not attach primary importance to multilateral initiatives – if we formulate it cautiously. If we want to say it more directly: Due to a general skepticism towards multilateralism and due to vital interests of social groups in the USA, which are reflected in government policies, the activities of WHO, UNAIDS and also the Global Fund are increasingly circumvented. We can identify – besides the general attitude of unilateralism – a mixture of interests affecting the way the US government is conducting PEPFAR, like interests of pharmaceutical companies and Christian beliefs and conservative opinions (cf. Burkhalter 2004). The general impetus to fund the fight against HIV/AIDS may arise from interests in

- presenting the USA not only as a war-faring nation but also as a soft power taking over responsibility for global problems like poverty and infectious diseases,
- political stability in the focus countries (where – at least in some countries – are great natural resources).

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[17] Many WHO and UNAIDS secretariat employees also criticise PEPFAR for not using the cheapest and safest ARV drugs, which – according to their principles and morals – should be the general way to help the AIDS patients (source: Interviews with WHO and UNAIDS secretariat staff members).

Although these interests are material interests as well as national self-interests they can improve the chances to realize social rights in the countries concerned. PEPFAR, born out of national interests, is a contribution to global health governance and supports the establishment of global social rights.

The activities in the fight against HIV/AIDS exemplify some of the contradictions and inconsistencies of the institutional modes of global governance: On the one hand powerful nation states backed the establishment of network regulation like the Global Fund (to weaken the WHO), which implicates a sharing of power with other actors, on the other hand they pursue their own interests by conducting bilateral programs like PEPFAR. It is interesting to see the different US strategies due to the institutional setting: Whilst the US delegation to the Fund tolerates the use of generics and condoms in the fight against HIV/AIDS, PEPFAR mainly gives money for patented drugs and propagates prevention methods like being abstinent instead of using condoms. The institutional context has an effect on the behavior and strategies of actors. Networks and partnerships force all participating actors to modify their strategies and to make compromises.

Both PEPFAR and the US contributions to the Global Fund show that powerful and rich nation states are willing to built compromises at the global level to tackle global problems – at least, if they are under pressure of global and national civil society. Certainly the exact impact of these pressures is difficult to determine. Nevertheless, at the same time nation states remain powerful actors and they can use the institutional context of these compromises, the partnerships and networks, to pursue their interests.

The – at least formally – central organization of global health governance and central global entity to provide and guarantee social rights in the field of health – the WHO – also tries to pursue its objectives via partnerships and networks. However, the WHO has the structural problem of not being a funding organization. Its power is based on its legitimacy as global organization of the countries, on knowledge and the capacities to set norms. The WHO has to rely on other (funding) organizations in implementing programmes.

The current main focus of global health governance on specific diseases is somehow contradictory to the realization of social rights for all, as it is only a selective strategy. However it helps realizing social rights (and the right to live at all) for victims of diseases, which can be seen as a fundamental right. The fight against infectious (and poverty related) diseases as well as the establishment of the Global Fund (with its exclusive activities on three poverty related diseases and its circumventing of the WHO) can be seen as a political and institutional compromise in the ongoing conflicts on social rights to health between richer and poorer countries, NGOs and pharmaceutical companies. Today's global health governance

does not foster the realization of comprehensive or guaranteed social rights, but it can provide the poor with flexible, occasional and temporary social rights.

5. Conclusion: Current Form of Global Heath Governance as Patchwork of Compromises

We started our analysis of conflicts on social rights in the political field of global health by explaining the commitments on social rights and especially on rights to health made by the global community. Due to the hegemony of neoliberal concepts in economic globalization during the 1980s and early 1990s progress in the realization of social rights was difficult in most developing countries as priority was given to economic and political freedom. Since the mid-1990s, insights have gained ground that poverty reduction and improvements in health do not automatically result from liberalization and economic growth and that parts of the global economy are marginalized or even excluded from trade and foreign investments (like especially parts of Africa). The Washington Consensus was questioned and thereafter modified: Today, poverty reduction and greater efforts to fight against infectious diseases like HIV/AIDS are at the top of the global political agenda to accompany the ongoing process of economic liberalization and to mitigate the biggest social problems resulting from it.

At the same time the globalization process has intensified the densification of interactions on the global level both in social/cultural and political terms. We face an increasing global awareness of conflicts and social problems. Richer countries realize that problems in marginalized regions are also to some extent their problems, like e.g. in the case of infectious diseases or HIV/AIDS threatening the economic and political stability in some countries and regions which might have international consequences. As the importance of health to social and political stability is acknowledged there is an increasing importance of health as a global public good that leads to strengthened global efforts. Thus, the increasing global awareness of problems and global activities to tackle the problems arise also from national self-interests.

Moreover, the global political space has become more important. Because of a lack of adequate reactions of nation states and international organizations to these global problems, actors of the civil society and the private sector play a prominent role in the evolving global governance – in particular in social and health policy affairs. This has a twofold effect. On the one hand corporations and their civil society equivalents like business associations use this political space to pursue their interests and to foster market liberalization that might undermine social rights. On the other hand actors like NGOs, advocacy groups and foundations strengthening social rights have great influence on politics.

The global community has accepted that the realization of the whole body of social rights laid down in the International Covenant on Economic, Social and Cultural Rights is not realistic at the moment. Nevertheless we can observe some progress in implementing social rights to health. We can say that the relationship between the moral power of advocacy and the changing pattern of material interests in the course of the integration of global society leads to the strengthening of the right to health.

The analysis shows that the current forms and effects of global health governance are characterized by institutional and political compromises. These compromises are the result of the global densification of social interactions and of the conflicts between actors pursuing material interests like containing health risks and reaching social and political stability (governments of industrialized countries) and securing profits (pharmaceutical companies) on the one hand and actors striking for social rights on the other hand. E.g. we can state a trade-off between keeping-up trade-rules and mobilizing additional financial resources to fight HIV/AIDS. The Doha Declaration, § 6 itself can be seen as a compromise between these actors.[18]

The new institutional setting of global health governance due to networks, partnerships and increased private activities strengthens social rights to health, but tend to circumvent the formal and democratically authorized UN organizations like the WHO. Powerful actors like governments from nation states can use this networks to achieve their goals, but at the same time they are compelled to make compromises. Furthermore, the focus of global health activities on specific diseases does not aim at the realization of comprehensive social rights. Yet, it strengthens a minimum right, which is the base of further social rights: the right of ill and poor to live.

In our analysis we have observed the integration of a progressively complex political field of global health governance characterized by relation to soft and hard international law, institutional arenas of conflicts, channels of financial transfers and manifold old and new actors linking this political field ever more closely to increasingly dense global social structures. There is no reason to expect a harmonious collaboration of these actors to promote the

[18] At the moment, a new approach to raise resources for public activities in medical R&D and to improve social justice in this field is under discussion: In February 2005, more than 160 health experts, scientist, politicians and NGO-activists signed a proposal for a legally binding Medical Research and Development Treaty. At the core of this treaty should be an obligation by member states – tied to the countries' gross domestic product – to finance medical R&D in the field of "diseases of poverty". The objective of this proposed treaty is to lower prices for drugs and other health products and to strengthen R&D of drugs for neglected diseases. This proposal, which will be discussed at the World Health Assembly in May 2005, could contribute exceedingly to the debate on global social rights, even if an adoption and entering into force is not realistic at the moment due to the current balance of power.

global right to health, but there is reason to expect that this global right to health (and that means above all the health of the poor) is becoming a much more significant global political issue than it was some decades ago.

Drawing a conclusion from this particular issue for the wider field of global social policy we can say that the evolving structures of global governance effect greater global social justice and cohesion. However, this process is still in its infancy and the level of social rights improvement reached so far is not stable as governance structures are fragile and fragmented.

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