

## VALUES FOR GLOBAL HEALTH GOVERNANCE

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“With globalisation, a single microbial sea washes all of humankind. There are no health sanctuaries,” so said Dr Gro Harlem Brundtland<sup>1</sup> in her 2000 Reith Lecture.

International travel enables not only microbes to cross borders but also scarce health workers. The aeroplanes that carry them exemplify the threat posed by global warming and pollution. While in the first class cabin the executives of global corporations may be seen as vectors of health and disease, bringing employment, increased prosperity and health but also working conditions, products and lifestyles with profound impacts on health. The poor farmer looking up at their vapour trails, unable to afford medicines for her family because she cannot compete in highly subsidised agricultural markets, reminds us of the impact of trade policy on the determinants of health.

This paper examines the values that shape our response to global health. It shows the importance of clarifying values and linking them to action in the European context. It also provides a series of case studies to demonstrate how different interpretations of values for global health lead to different policy outcomes.

### Values for global health

Clare Short, the former UK Secretary of State for International Development, drew parallels between the emergence of the welfare state, in response to the industrial revolution, and the need to establish global governance to respond to globalisation. Industrialisation moved production out of the home and into factories and industrial towns, creating a physical as well as social distance between those suffering the health consequences of industrialisation and those with economic power. While the welfare state can be seen as an expression of Benthamite utilitarian values, or the realisation of national citizen's rights, it took 150 -200 years of struggle, much of it violent, for it to emerge in its modern forms across the world.

Globalisation creates even greater distance between the world of corporate power and the poor who serve it. Takeru Kobayashi, the “World Eating Champion” sponsored by Nathans through its global outlets, can be seen as a symbol of corporate greed and its impact on the health of the first generation of Americans who will live shorter lives than their parents due to obesity. Of course foreign direct investment and responsible employment and marketing can also have a very significant positive impact on health. By and large those who suffer the worst poverty and health are those who are neglected by globalisation, such as the women of Somalia and Zimbabwe, one a failed state, in conflict since 1988, the other heading in the same direction.

Neither the negative or positive impacts of globalisation can be addressed by national governments, since the impact of globalisation is to increase the significance of trans border power. Growing inequity and violence both between and within countries suggests that the current structure of global governance is inadequate to address this challenge. The emergence of new values of global citizenship may lead to the acceptance of global responsibilities and governance, but it is important to bear in mind the extent of global inequity that is currently tolerated. Current global and local inequity in health and wealth is a damning testament of current values.

Thus a discussion of global health must start by recognising that, however well values for global health are articulated in ethical debate, they are not reflected in action of the scale required by current challenges. The agenda for the necessary re-invention of global governance values and structures was set out by Ilona Kickbusch

in her keynote speech to the World Federation of Public Health Associations conference in 2004<sup>2</sup>. This agenda requires a careful re-examination of the values that guide health governance, to ensure they are fit for this new purpose. It also calls for a re-examination of the structure and processes of global governance to connect the many local, regional and global actors that are key stakeholders in global health.

The Madrid Framework<sup>3</sup> explores the values in health policy, the tensions between them and their resonance with current and future health policy. In brief the headings of the Madrid Framework values are:

1. Health and well being
2. Equity and fairness.
3. Choice
4. Democracy
5. Stewardship
6. Evidence
7. Efficiency
8. Synergy
9. Sustainability
10. Interdependence
11. Creativity

While such value statements can provide a focus for international debate, they do not necessarily have the same meaning for all participants. Differences of interpretation and different ways of resolving the inherent tension between these and other values can be as important as the values themselves in guiding action<sup>4</sup>. As examples, how much is equity and fairness in relation to the health of others valued in relation to personal health and well being? How much democracy in international institutions is compatible with national interests and choices? These are uncomfortable questions.

The conclusion for action is that a strategy for global health is required at European Union level. The starting point for this is to clarify European understanding of value terms and give practical expression to European values for health by linking them to policy choices in global health. This thought led to the preparation of the “European Perspectives on Global health: A Policy Glossary”<sup>5</sup>. This in turn has been recognised as an important influence on the emergence of a strong global dimension in the European Unions’ current health policy<sup>6</sup>.

The “Policy Glossary” calls for the engagement of a wide range of actors in the development of a “European Strategy for Global Health”. This recognises that while nation states are important they are no longer the intermediaries for all such actors, some being more local and others more international. Thus the Bretton Woods closed fora for inter governmental cooperation are being superseded by the open market place or “agora” allowing much stronger connection between the local and the global. This agora will be guided by emerging values for global health.

### **Interpreting values for global health**

The dimension of the Madrid framework that is most associated with global health - the realisation of the interdependence of global health. However, as the following case studies show, not only are there great differences in the interpretation of this value but policy depends upon the interaction with many other values. The Millennium Development Goals provides an example of a human rights based approach, US aid policy shows an approach based on enlightened self interest, the Netherlands is used as an example of health as a global public good and the UK shows an approach to health as a product of the impacts of globalisation. These are simplified models, in practice each approach is based on a mix of complex values.

### **Millennium Development Goals: Health as a human right**

The UN Charter declaration of human rights of 1948 refers to the right to a standard of living adequate for health and well being and a universal right to life. However, the preamble to the World Health Organisation constitution, prepared at the same time, states that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..” The interpretation of this value depends on the perspective of the commentator. Many Europeans refer to health as a human right, reflecting the principle of solidarity which is the basis for health care systems in most countries. Where access to health care is not universal within the national system, as in the US, this may be less obvious.

The acceptance of health as a human right implies a value of solidarity not only between members of national communities but as an element of global citizenship that people should be able to demand from governments and from the international community. Kofi Annan has stated “It is my aspiration that health will finally be seen not as a blessing to be wished for but as a human right to be fought for”.

In practice commitment to this value seems limited; even within the European Region of WHO life expectancy varies by more than 15 years and annual expenditure on health ranges from \$3,500 per capita in Switzerland, to less than \$50 per head in Tajikistan<sup>7</sup>. Global comparisons are even more stark, with life expectancy varying from 80 in Sweden to less than 45 years in Zimbabwe. G7 countries spend an average of \$2400 per capita on health and low income countries spend \$18 per capita on average<sup>8</sup>.

The Millennium Development Goals can be seen as a statement of compromise on the value of health and other human rights. It set goals with respect to poverty, education and health which were designed to reduce but not eliminate some of the worst deficits in human rights. These targets were intended to be affordable within the resources committed to aid. It was signed by 189 countries of the United Nations and included the following clause: “We urge developed countries that have not done so to make concrete efforts towards the target of 0.7% of gross national product (GNP) as official development assistance (ODA) to developing countries...”

The target for ODA was set in 1970 following the Pearson Commission Report, the intention was to achieve total flows of assistance to developing countries of 1% of GNP, of which ODA would contribute 0.7%. This compares with expenditure on ODA in 2004 of 0.36% of GDP for the EU and 0.16% for the US. Over the thirty five years in which this target has been adopted, expenditure on aid rose in real terms over the first fifteen years, then reduced for the next fifteen and is now once more increasing in real terms, to some extent reflecting increases in expenditure in health. The proportion of aid devoted to health has risen rapidly, from less than 5% in 2000<sup>9</sup> to 9% of total aid of \$78.6 billion in 2004<sup>10</sup>.

The Commission on Macroeconomics and Health (CMH) of 2001 identified a “set of essential interventions” for basic health at a cost of \$34 per capita, to be funded from a combination of aid and local funding, enabled by debt reduction programs<sup>11</sup>. This compares with the WHO 2002 estimate of per capita health spend of \$18 per capita (44 per cent being out of pocket expenses) in low income countries. The specific target for health aid indicated by the CMH was to achieve annual flows of \$27 billion by 2007, rising to \$38 billion by 2015. This compares with the current total ODA for health of around \$6 billion.

Jeffrey Sachs has pointed out that in comparison with military expenditure the sums required to address global health issues are minor, while the benefits are immense<sup>12</sup>. Nevertheless it is now clear that both the essential interventions identified by the CMH and the “affordable” MDG targets are likely to be grossly under funded. At the

“Making Globalisation Work for All” conference in February 2004 the UK Chancellor, Gordon Brown said “With the prevailing air of apathy many of the (MDG) goals are unlikely to be met within the next 100 years, let alone by the planned date of 2015”. Goals that are least likely to be met are those relating to health in Africa, to reduce child mortality by 2/3, reduce maternal mortality by ¾ and halt the spread of HIV/AIDS, Malaria and Tuberculosis<sup>13</sup>.

### **US: Global health as a threat to national interests and security**

International efforts to address global health in the 19<sup>th</sup> century, dating from the first international sanitary conference of 1851, attempted to address the threat to the health and trade of rich countries<sup>14</sup> posed by the spread of epidemics of Cholera and Yellow fever. It seems that the scope for action on such issues was limited by a fear that they could become impediments to trade and the national interests of the “Great Powers”, a view that was later reflected in debate at the World Trade Organisation.

The concept of global health, centred on the threat of infectious disease also found a later echo - in the 1997 report of the American Institute of Medicine on global health, which was sub titled “Protecting our People, Enhancing our Economy and Advancing our International Interests”<sup>15</sup>. This report influenced thinking in both Clinton and Bush Administrations. It led to the elaboration of global health issues in US foreign policy and a redefinition of national security issues to include global health threats.

At international level HIV/AIDS has become a core issue for the UN Security Council and an issue of “hemispheric security” for the Americas<sup>16</sup>. In Africa three heads of state have commented that HIV/AIDS threatens to make their countries ungovernable. David Feachem has noted that failure to halt the spread of the pandemic in the Indian sub continent could have massive implications for the stability of the region<sup>17</sup>. David Fidler describes how the positioning of global health as a threat to national interests and security has raised it to “high policy” status in US international relations<sup>18</sup>.

The frank recognition of the importance of global health to national interests and security was clearly a factor leading to the decision to increase US government expenditure on official development assistance (ODA) from 0.11% to 0.16% of gross national product (GNP) between 2000 and 2005 with the highest rate of increase in health related aid. ODA rose to \$19 billion in 2004 of which some 35% was directed to low income countries, the amount allocated to health is believed to have risen from less than 5% to over 8%<sup>19</sup>.

Enlightened self interest may also have been a factor in the increase in private US international, philanthropic aid, which is estimated at some \$16 billion in 2002, excluding personal remittances<sup>20</sup>. However it cannot be assumed that all aid from one country is motivated by one interpretation of values. It seems more likely than the international perspectives fostered by global business have increased global philanthropy.

Emphasis on the threat posed by infectious diseases has resulted in increased investment in disease specific programmes, such as HIV/AIDS prevention and treatment, tuberculosis treatment, including measures to counter the spread of multi drug resistant strains, the eradication of polio and measures to monitor and control influenza (including avian flu) and new and re-emergent diseases such as SARS. All of these are diseases posing a direct threat to health in OECD countries. When the Global Fund was established its remit was extended to include not only HIV/AIDS and TB but also Malaria, to ensure the interests of donor countries were not seen to predominate over the needs of the recipients.

Disease based vertical programmes provide more visible results and can be more readily monitored and proofed against corruption, because they make it possible to

develop and apply systematic approaches and resources through partnership between government, voluntary and private sector. The disadvantage of such programmes is that they can impose high coordination costs on recipient health ministries and divert doctors and other resources away from basic health services which impact on a wide range of health issues in a less visible way.

US aid policies for global health also reflect national self interests and security in other ways. The Millennium Development Account is a mechanism to link general budgetary support aid to the performance of recipient countries in respect of measures of “ruling justly”, “investing in people” and “economic freedom”.

The President’s Emergency Plan for AIDS Relief (PEPFAR) introduces an overtly sectarian perspective, in its focus on faith based organisations and the ABC approach (abstinence, be faithful, use a condom). All US health aid is constrained by the so called “gag rule” that prohibits funding of any organization that performs abortions or advocates for the liberalization of abortion laws in other countries. From a European perspective this non secular approach is of deep concern.

There has also been an increasing focus on the importance of aid, particularly health aid, in projecting what has been described, in reference to US foreign policy, as “soft power” - the ability to influence people’s thinking and perception to want the things you want<sup>21</sup>. Thus US aid is now made more apparent to recipients and more prominent in international meetings. For example, while the US provides far less health aid than the EU and its member states, it appears to dominate and lead action against HIV/AIDS and other aspects of international health aid.

### **The Netherlands: Health as a Global Public Good**

The concept of global public goods, as those which affect all countries and regions and may have intergenerational impacts, all may share and from which none can be excluded, was first mooted by Inge Kaul<sup>22</sup> in 1999, though its origins in the discussion of public goods can be traced back to the 1950s. Specific health measures which may be regarded as global public goods, applying a narrow definition of the term, include: shared health research knowledge, surveillance for diseases, measures to prevent, control and eliminate global diseases and measures to reduce or counter global pollution and climate change.

Ilona Kickbusch applies a broader interpretation of health as a global public good, seeing common commitment to health as defining values of global citizenship and global governance<sup>23</sup>. Strengthened global governance for health is seen as key to global health security and international justice for health. It requires new forms of international funding and greater capacity at WHO and elsewhere to identify health threats, including the health impacts of actions by governments or international corporations and to intervene to protect global health goods and rights. This in turn requires that health should be a key social responsibility of governments and business, backed by international charter. These measures would underpin the health rights of global citizens in a globalising world.

International financing of global goods is a crucial first step towards this vision. These options include the issuance of special drawing rights by the International Monetary Fund, carbon taxes and the so called Tobin Tax proposal for taxation of the international movement of finance<sup>24</sup>. As yet there has been no international commitment to the adoption of any of these measures.

Perhaps the country which best exemplifies the values of global health as a global public good is the Netherlands. In 2004 Netherlands ODA amounted to \$4.2 billion, which was 0.8% of GNP. They have a longstanding commitment to sustainable development and poverty alleviation and were the first country to meet the 20/20 Commitment agreed at the World Summit for Social Development, held in

Copenhagen in March 1995, which agreed to match developing country spending of 20% of government budget on social services with a matching 20% of aid. Some 55% of ODA is directed to low income countries and 73% is bilateral, 27% multilateral. They are a supporter of UN bodies in providing un-earmarked funding for their operations. Human rights are also strongly embedded in Dutch development assistance with clear rules that prohibit funding for countries which breach human rights.

In recent years Dutch bilateral ODA has been targeted at and monitored against the achievement of the MDGs. ODA is co-ordinated by the Netherlands Ministry of Foreign Affairs, under one budget head known as the Homogeneous Budget for International Co-operation.

The aid implementation agency 'Netherlands Development Assistance' works in cooperation with other ministries, institutes and partnerships. For example, the HIV/AIDS programme is jointly managed by the Ministry of Health, Welfare and Sport (VWS) and the Dutch AIDS Fund. VWS has its own International Affairs Directorate within which is a department responsible for global health issues.

Alongside these commitments the Netherlands has played a major role in programmes of research and support on global health issues, through its research and training institutes, and particularly in respect of tuberculosis control and treatment. A conference on global health issues held by the VWS in December 2003 recognised that there are many reasons for supporting action on global health. While not detracting from the focus on the MDGs there are also good reason to work on public health measures with Eastern European countries, since these are seen as the health defences - "the health polders" for the Netherlands and Europe.

It is also politically important to build social and cultural links with countries who will have substantial voting rights in the new EU. Moreover it is recognised that these countries produce an excess of clinical staff, who could be valuable to the Netherlands, which suffers from medical staff shortages. Recruitment of nurse to the Netherlands from poorer countries has led to public criticism of the damage this does to health in the countries from which staff are taken<sup>25</sup>. For these reasons the Netherlands has led more EU and bilateral assistance programmes with EU accession states than any other country.

### **The UK: Global health impacts of globalisation**

The conceptual framework for the analysis of the impacts of globalisation on global health was put forward by Kelley Lee in 1998<sup>26</sup>. This examines the processes that are intensifying human interaction, reducing the barriers of time, space and ideas which have separated people and nations in a number of spheres of action including economic, environmental, social and cultural, knowledge and technology and political and institutional, each of which has a profound impact on health,

These interdependencies were identified and explored in the Nuffield Trust programme "Global Health: A local Issue"<sup>27</sup>. Even within a single field of action the impact of globalisation was found to be complex. Thus while economic globalisation can bring employment, greater prosperity and health, it may also result in the weakening of workplace health and environmental controls as countries compete in a "race to the bottom", to attract investment<sup>28</sup>. It largely results in the creation of employment for women, who, without further support, may suffer a double burden as wage earners and the main resource for family health and care<sup>29</sup>.

The price of entry to global markets, demanded by the General Agreement on Trade and Services (GATS) and the World Trade Organisation (WTO) was particularly high for the health sector. Liberalisation of trade has opened health care markets to the privatisation of profitable sectors, resulting in an undermining of state health systems

by the drain on resources and personnel both to the private sector and to other countries<sup>30</sup>. Some countries lost 90% of locally trained doctors to international migration<sup>31</sup>, almost 5000 doctors were recruited to the UK in 2000/1 from non EU countries. The Trade Related International Property Rights Agreement (TRIPs) required the observation of international patents, which threatened to make some drugs unaffordable<sup>32</sup>. When economic problems hit, the price of assistance from the International Monetary Fund (IMF) also fell heavily on health services through imposed limitations on public spending<sup>33</sup>.

Internationalisation of local markets has exposed developing countries to a wide range of lifestyle, smoking, alcohol and diet-related non-communicable diseases, including diabetes, heart disease, lung and bowel cancer<sup>34</sup>. Furthermore, the conflicting demands of different cultural influences may have been a factor in the rapid growth of mental illness.

Many middle income countries have felt that the economic benefits of globalisation have outweighed the health costs, and globalisation remains a highly valued principle for many such countries<sup>35</sup>. However, the poorest countries have experienced costs, in terms of increased environmental damage and extreme weather conditions, rapid increases in non communicable disease and migration of health workers, but have had little or no economic benefit. The exclusion of agriculture from trade liberalisation meant that they were unable to compete in international markets and their farmers could be impoverished by the importation of subsidised produce from rich countries. It is estimated that agricultural subsidies amount to some \$300 billion per year and restrict world economic growth by about \$500 billion<sup>36</sup>, this created economic losses to developing country producers of approximately one third of this level, this is twice the level of aid to developing countries.

A more exhaustive analysis of models of the consequences of globalisation for global health is provided by Ronald Labonte and Renee Torgeson<sup>37</sup>.

UK policies for development recognised the complex interdependence of globalisation and the determinants of global poverty and health in the White Paper launched in 2000, "Making Globalisation Work for the Poor"<sup>38</sup>. This committed the UK government to action on issues such as: reducing agricultural subsidies, increasing access to essential medicines, improving information to consumers about environmental and working conditions, supporting the development of global civil society, and ensuring that poverty reduction programmes were environmentally sustainable.

Since 2000 the UK government has taken a wide range of policy initiatives and leadership actions, which reflect this broad based approach. These include a leading role in the Doha trade round negotiations and G8 summits, to broker agreement on revision to TRIPs to improve access to essential medicine<sup>39</sup>, to address the unfairness of agricultural subsidies<sup>40</sup>, to achieve international agreement to increase debt relief and aid<sup>41</sup> and to develop comprehensive proposals to address the problems of development in Africa<sup>42</sup>. The aim of increasing aid to achieve the UN target of 0.7% of GNP by 2013 was announced in 2004.

The 2002 International Development Act, requires that virtually all UK ODA must be provided for the purpose of either furthering sustainable development or promoting the welfare of people in a way that is likely to contribute to the reduction of poverty. ODA includes bilateral and multilateral aid and debt relief. Health is seen as a key to improving life chances and hence achieving poverty reduction as a human rights issue. Total UK ODA in 2004 is estimated at \$7.8 billion of which 43% is multilateral aid and 55% is bilateral. Health aid has increased as a percentage of total UK bilateral ODA from 11.4 % in 1996/7 to 16.5% in 2003/4. At the same time most aspects of poverty reduction also lead to health improvements through better

education, safe water, improved nutrition and employment opportunities. The main operational policies for UK ODA have been to provide general budgetary support and debt relief to the poorest countries. Currently 80% of UK bilateral aid goes to low income countries.

A broad based evaluation of the contribution of OECD countries to development is provided by the 2004 Commitment to Development Index prepared by the Center for Global Development<sup>43</sup>. This index scores seven factors: aid, trade, investment migration, environment, security and technology. A score derived from these factors shows that in 2005 the UK was rated 10<sup>th</sup> in relation to 21 OECD countries, due to low scores in respect of security and migration.

Specific actions on global health include a programme on international HIV/AIDS, which was launched in 2004 as a cross government, cross sector initiative<sup>44</sup> led by the Department for International Development (DfID). Action to limit direct overseas recruitment from vulnerable countries was announced by the Department of Health (DH) in 2001, however, the effectiveness of this measure has been questioned since it applies only to direct recruitment to the NHS<sup>45</sup>. The DH sponsors the Health Protection Agency which in 2004 developed a strategy to support international health (through its laboratory and advisory services). DH also put forward measures to assist NHS Trust to form twinning relationships and exchange staff and know how with developing countries. The Department of Health is preparing a UK strategy to support global health, following the lead of Switzerland, which has already produced a national strategy for global health.

Treasury supported actions for global health include tax relief for drug donation programmes and tax incentives to promote research and development on diseases predominantly affecting developing countries<sup>46</sup>, oriented towards research on vaccines. The International Finance Facility and an Advanced Purchase Fund for medicines have both been launched in 2005 as pilot programmes. In addition Gordon Brown as Chair of the Finance Committee of the IMF has made recommendations to increase aid funding, write off debt and mitigate the impact of IMF restrictions on public sector spending for indebted countries.

## **Conclusion**

This paper discusses the interpretation of values for global health. The next step, which it introduces, has been the creation of the European Partnership for Global Health and preparation of "European Perspectives on Global Health: A Policy Glossary" as a starting point for a "European Strategy for Global Health". The case studies presented here show that different interpretations of values in global health policy have real outcomes for the level and nature of aid. While it is neither possible nor desirable to impose one interpretation of values for global health it is vital that the ethical debate should engage all sectors of society and should focus on the practical implications of values for action on global health.



## References

- <sup>1</sup> Gro Harlem Brundtland “Respect for the Earth: Health and Population” Reith Lecture, BBC (2000)
- <sup>2</sup> Ilona Kickbusch “The End of Public Health As We Know It: Constructing global Health in the 21<sup>st</sup> Century” Keynote speech WFPHA 10<sup>th</sup> Annual Conference Brighton (2004)
- <sup>3</sup> Marshall Marinker “The Madrid Framework of health policy and Governance” European Health Forum Gastein 2004
- <sup>4</sup> Marshall Marinker (ed) “Constructive Conversations About Health: Policy and Values” Radcliffe Oxford 2006
- <sup>5</sup> Ilona Kickbusch and Graham Lister “European Perspectives on Global Health: A Policy Glossary” European Foundation Centre Brussels 2006
- <sup>6</sup> “Health in Europe: A Strategic Approach: Discussion Document for a Health Strategy” Health and Consumer Protection Directorate-General Brussels 2006
- <sup>7</sup> WHO “Core Health Indicators: Per capita total expenditure on health in international dollars 2002.
- <sup>8</sup> Ronald Labonte, Ted Schrecker, David Sanders, and Wilma Meeus “Fatal Indifference: The G8, Africa, and Global Health” University of Cape Town Press/IDRC 2004
- <sup>9</sup> Ronald Labonte, Ted Schrecker, David Sanders, and Wilma Meeus “Fatal Indifference: The G8, Africa, and Global Health” University of Cape Town Press/IDRC 2004
- <sup>10</sup> Helen Fisher “Official Development Assistance increases further - but 2006 targets still a challenge” OECD Press release 11/04/2005
- <sup>11</sup> Commission on Macroeconomics and Health. “Macroeconomics and Health: Investing in Health for Economic Development”. Geneva: WHO 2001.
- <sup>12</sup> Jeffrey D. Sachs “Achieving the Millennium Development Goals: Health in the Developing World” Speech at the Second Global Consultation of the Commission on Macroeconomics and Health Geneva, October 29th, 2003
- <sup>13</sup> DfID Annual Report 2003 HMSO 2004
- <sup>14</sup> Kelley Loughlin and Virginia Berridge “Global Health Governance: Historical Dimensions of Global Governance” Centre on Global Change and Health LSHTM and WHO (2002)
- <sup>15</sup> Institute of Medicine “America’s Vital Interest in Global Health: Protecting Our People, Enhancing Our Economy, and Advancing Our International Interests” Institute of Medicine (1997)
- <sup>16</sup> Ulysses Panisset “Health and Hemispheric Security” PAHO, WHO (2002)
- <sup>17</sup> Sabin Russell “AIDS In India - Unanswered Questions - Epidemic imperils the future - Nation could face Africa-like disaster” San Francisco Chronicle July 8 2004
- <sup>18</sup> Fidler, D, 'Germs, Norms and Power: Global Health's Political Revolution', Law, Social Justice & Global Development Journal (LGD) (2004)
- <sup>19</sup> Anup Shah “The US and Foreign Aid Assistance: Sustainable Development” Global Issues 20 Aug (2005)
- <sup>20</sup> Carol Adelman “Aid and Comfort” Tech Central Station, 21 August 2002.
- <sup>21</sup> Joseph Nye “Soft Power : The Means to Success in World Politics” Public Affairs, June 2005
- <sup>22</sup> Kaul, Inge, Isabelle Grunberg, and Marc A. Stern. “Defining Global Public Goods.” In Inge Kaul, Isabelle Grunberg, and Marc A. Stern, eds., Global Public Goods: International Cooperation in the 21st Century. New York: Oxford University Press. (1999)
- <sup>23</sup> Ilona Kickbusch “The End of Public Health As We Know It: Constructing global Health in the 21<sup>st</sup> Century” Keynote speech WFPHA 10<sup>th</sup> Annual Conference Brighton (2004)
- <sup>24</sup> Jullyette Ukabiala “Can the financing gap be closed? UN panel suggests new international taxes to help fund development” Africa Recovery, Vol.15 #4, December (2001)
- <sup>25</sup> Frits Tjadens “Health care shortages: where globalisation, nurses and migration meet” EuroHealth Vol8 No 3 Summer (2002)
- <sup>26</sup> Kelley Lee “Globalisation and Health Policy a Review of the Literature and Proposed Research and Policy Agenda” London School of Hygiene and Tropical Medicine August (1998).
- <sup>27</sup> Luise Parsons and Graham Lister “Global Health: a Local Issue” The Nuffield Trust 1 Nov1999
- <sup>28</sup> William Greider, Ralph Nader (Editor), Margaret Eleanor Atwood “The Case Against Free Trade: GATT, NAFTA, and the Globalization of Corporate Power” Earth Island Press (1993)

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- <sup>29</sup> Aakanksha Pande “Nimble Fingers Tired Bodies” Nuffield Trust (2003)
- <sup>30</sup> David Woodward “Trading Health for Profit: the Implications of the GATS and Trade in Health Services for Health in Developing Countries” (2003)
- <sup>31</sup> James Buchan, Delanyo Dovlo, “International Recruitment of Health Workers to the UK: A Report for DFID”, DFID Resource Centre (2004)
- <sup>32</sup> Commission on Intellectual property Rights “Integrating Intellectual Property Rights and Development Policy” Commission on Intellectual Property Rights, London (2002)
- <sup>33</sup> Joseph Stiglitz “Globalization and its Discontents” W.W. Norton and Company New York 2002
- <sup>34</sup> Derek Yach and Pekka Puska “Globalization, Diets and Noncommunicable Diseases” WHO 2002
- <sup>35</sup> David Dollar “The Poor Like Globalization” YaleGlobal, 23 June 2003
- <sup>36</sup> HM Treasury “Trade and the Global Economy: The role of international trade in productivity, economic reform and growth” HMSO 2004
- <sup>37</sup> Ronald Labonte, Renee Torgeson “Frameworks for Analysing the Links between Globalization and Health” WHO Geneva, (2003)
- <sup>38</sup> “Eliminating Poverty: Making Globalisation Work for the Poor” Department for International Development The Stationery Office 2000
- <sup>39</sup> DFID Access to Essential Medicines Report to the Prime Minister HMSO (2002)
- <sup>40</sup> Working Group Report to the Prime Minister on Increasing Access to Essential Medicines in the Developing World UK Government Plans and Actions DfID HMSO (2004)
- <sup>41</sup> HMT and DfID “International Finance Facility” January HMSO (2003)
- <sup>42</sup> Commission for Africa “Report” Office of the Prime Minister 2005
- <sup>43</sup> Center for Global Development “Ranking the Rich: The 2004 Commitment to Global Development Index” 2005
- <sup>44</sup> DfID “Taking Action: The UK’s strategy for tackling HIV and AIDS in the Developing World” DfID (2004)
- <sup>45</sup> James Buchan, Delanyo Dovlo, “International Recruitment of Health Workers to the UK: A Report for DFID”, DFID Resource Centre (2004)
- <sup>46</sup> HM Treasury “Budget Report 2001” HMSO 2001