

SDG 3

Corporate influence on the global health agenda

BY K M GOPAKUMAR, THIRD WORLD NETWORK (TWN)

A range of industries are attempting to influence the national and global health agenda, outlined in SDG 3 on health and well-being, in order to pursue their business interests. These include: (1) industries that are in the business of manufacturing or selling health products such as medicines, vaccines, medical devices and nutrition supplements; (2) industries whose products have direct adverse impacts on health such as tobacco, arms, alcohol, food and beverages, automobiles and chemicals; and (3) industries that benefit from the scaling up of health services, such as those dealing with insurance and information and communications technology. With regard to the first two, given their proactive interest in the increased sale of their products, their influence may result in technical fixes without tackling the social determinants of health and constraints on policies to address these. With regard to the second, their defensive interest lies in slowing down a comprehensive approach to healthcare, especially strategies of prevention, because any attempt to promote public health would result in regulating their business practices. Instead, they promote purportedly quick fixes with their products and services.

Global Partnerships facilitate corporate influence on public policy

The promotion of Global Partnerships as a vehicle to achieve the SDGs undermines the primary responsibility of the State to ensure human rights, including the right to health. Corporate sector participation in multi-stakeholder partnerships “on an equal footing” with government and CSOs, as promoted by the World Economic Forum,¹ provides the opportunity to unduly influence the public health agenda. Corporations can influence partnerships either through their participation in the governance of partnerships or their financial contributions or both.

SDG 3 sets nine targets on the following health issues: maternal and child health, reproductive health, communicable diseases, non-communicable diseases, substance abuse, universal health care, road accidents and chemical and air pollution. There are already multi-stakeholder partnerships in most of these areas with an active involvement of the private sector, especially multinational corporations.

Relying on multi-stakeholder partnerships to achieve the SDG 3 targets bear the risk of facilitating corporate profiteering. While not mentioned in SDG 3 targets specifically, multi-stakeholder partnerships are considered an important vehicle to achieve the SDGs, and are clearly stated under SDG 17 on means of implementation, specifically in targets 17.16 on multi-stakeholder partnerships and 17.17 on public, public-private and civil society partnerships. In addition, the UN Knowledge Platform on SDG 17, which deals with means of implementation, states:

¹ www3.weforum.org/docs/WEF_2NETmundialInitiativeFAQ.pdf.

*“Achieving the ambitious targets of the 2030 Agenda requires a revitalised and enhanced global partnership that brings together Governments, civil society, the private sector, the United Nations system and other actors and mobilises all available resources”.*²

The multi-stakeholder partnerships are designed not only to mobilize financial resources but also for sharing knowledge, expertise, technologies and financial resources to support the achievement of SDGs (target 17.16). However, the 2030 Agenda and the SDGs are silent on the risk of conflicts of interest emanating from the multi-stakeholder partnerships. In the absence of safeguards, the global health agenda set out under SDG 3 bears the risk of corporate influence.

In the area of maternal and child health, the most important initiative is the UN Secretary-General’s “Every Woman Every Child” (EWEC) initiative, a multi-stakeholder partnership covering various areas of health. EWEC describes itself as a global movement “which presents a roadmap to ending all preventable deaths of women, children and adolescents within a generation and ensuring their well-being” and is critical for the achievement of SDG 3.³ As a multi-stakeholder partnership with the representation of the private sector, philanthropic foundations and NGOs on its High-Level Steering Group, the initiative accepts financial resources from a range of private sector corporations, including pharmaceutical companies.

Similarly, in the area of tuberculosis (TB) and malaria, the World Health Organization hosted two partnerships with the participation of philanthropic foundations and the corporate sector, namely “Stop TB Partnership” which provides grants to “reach and treat” people with TB through the UN Foundation,⁴ and the “Roll Back Malaria” partnership launched by the WHO in 1998, but pretty much abandoned for lack of funding.

Most of these partnerships do not put any restrictions on the inclusion of industries on the basis of their commercial interest. In the case of the Partnership for Maternal, Newborn & Child Health (PMNCH) hosted by WHO, for example, it excludes entities related to tobacco, the arms industries or breast milk substitute industries from joining the partnerships, but despite efforts to change this policy, places no restrictions on the pharmaceutical or food and nutrition industries which may also have negative public health impacts.

Apart from this, the leading voice in the area of non-communicable diseases (NCDs) is the NCD Alliance,⁵ an NGO partnership that not only receives financial support from the private and philanthropic sector, especially the Gates Foundation, but also provides a role for that sector in its governance. Critics have raised the concern that the involvement of the pharmaceutical and medical devices industry restricts the advocacy around affordable medicines and medical devices.

Despite the need to avoid conflict of interest in WHO’s Action Plan for the Prevention and Control of NCDs, the WHO allowed the World Economic Forum to co-host a market place breakfast and networking dinner during the first global meeting of the national NCD programme managers and directors.⁶ Such practices allow the private sector to safeguard their core business interests by preventing comprehensive actions against NCDs, including the regulation of food and beverages industries.

In the area of road safety, mentioned in target 3.6 Jean Todt, the UN Secretary-General’s Special Envoy for Road Safety⁷ is the president of Fédération Internationale de l’Automobile (FIA – International Automobile Federation), and former CEO of Ferrari. FIA receives financial support from automobile manufacturers. WHO is partnering with FIA to manage the Road Safety Fund. The UN Road Safety Collaboration, a public-private partnership coordinated by

2 <https://sustainabledevelopment.un.org/sdg17>.

3 www.everywomaneverychild.org/about/#sect1.

4 www.unfoundation.org/what-we-do/partners/organizations/stop-tb-partnership.html.

5 <https://ncdalliance.org/who-we-are>.

6 www.who.int/nmh/events/2016/forum_breakfast_program.pdf?ua=1.

7 www.un.org/press/en/2015/sga1565.doc.htm.

WHO has representation from tyre manufacturers, a steel manufacturer and the International Motorcycle Manufacturers Association, as well as the FIA.

According to the Peoples' Health Movement, "From a public health point of view, there is considerable scope for linking the objectives of cutting greenhouse gas emissions, controlling NCDs and reducing road trauma".⁸ The involvement of industry may curtail the possibility of promoting such a comprehensive approach.

In terms of means of implementation for SDG 3, a central strategy is the research and development of vaccines, for "the communicable and non-communicable diseases that primarily affect developing countries" (target 3.b), a strategy also applied to tackling infant and child mortality (target 3.2). Gavi, the Vaccine Alliance (formerly known as Global Alliance for Vaccines and Immunisation) is a public-private partnership designed "to leverage not just financial resources but expertise too, to help make vaccines more affordable, more available and their provision more sustainable, by working towards a point where developing countries can pay for them themselves", in line with target 3.b.⁹

According to the Access Campaign of Médecins Sans Frontières, Gavi's advanced market commitment for pneumococcal conjugate vaccines¹⁰ provided "a late-stage public- and philanthropic-funded subsidy of US\$ 1.5 billion that to date has benefitted two multinational manufacturers (Pfizer and GlaxoSmith-Kline) that had already committed to producing a profitable vaccine."¹¹ The report raises serious con-

cern about the sustainability of the Gavi strategy and states: "Even at the lowest global prices, the introduction of the newest vaccines against pneumococcal and diarrhoeal diseases (pneumococcal conjugate and rotavirus vaccines, respectively), and against cervical cancer (human papillomavirus vaccine) has increased the cost of the full vaccines package 68-fold from 2001 to 2014."

Similarly, corporate interest continues to prevent the use of flexibilities contained in the Trade-related Aspects of Intellectual Property Rights Agreement (TRIPS) administered by the World Trade Organization. These flexibilities, which balance public interests (including public health) against the temporary exclusive rights conferred on a patent holder, are a crucial means of implementation to ensure access to affordable medical products. The pharmaceutical industry through the Pharmaceutical Research and Manufacturers' Association of America (PhRMA) is known to lobby the United States government to exert political pressure on developing countries to prevent the use of TRIPS flexibilities. In 2016 Novartis, a pharmaceutical corporate giant, lobbied its home government, Switzerland, which then openly pressured the Colombian government against issuing a compulsory license requirement on *imatinib mesylate*, a life-saving cancer medicine.¹²

Universal Health Coverage (UHC), agreed in target 3.8 is another area of exploitation for corporate health care providers and the insurance industry to advance their business interests. Instead of providing publicly funded comprehensive health care services, the original concept of Universal Health Care, the focus of the reductionist UHC is to eliminate financial risks to consumers while buying health care services. Further, UHC attempts to provide a minimum package of care instead of comprehensive care.

The fear that private sector health care providers and insurance firms would benefit most from the current UHC model was realized when the initial SDG indicator on UHC was finalized, which stated: "Number of people covered by health insurance or a public health

8 https://docs.google.com/document/d/1yaXbSISfuoJZL0_RCRawwD8IUv2l-pUe0yppygd5w/edit.

9 www.gavi.org/about/mission/.

10 This vaccine gives protection against 13 types of pneumococcal bacteria that cause pneumococcal disease. There are over 90 different types of pneumococcal bacteria, and they cause a range of problems including ear infections and pneumonia. Pneumococcal disease can also cause life-threatening conditions such as meningitis and septicemia (blood poisoning). Vaccines have been produced to protect against the types that cause the most disease (<http://vk.ovg.ox.ac.uk/pcv>).

11 Médecins Sans Frontières (2015), p. 17.

12 Goldman/Balasubramaniam (2015).

Healthcare is not a commodity but a public good

BY SANDRA VERMUYTEN, PUBLIC SERVICES INTERNATIONAL (PSI)

We need social protection systems that are based on solidarity, sharing of risks, and built on collective bargaining and social dialogue, democratic structures and long-term strategies to combat poverty and address inequalities and inequity. Universal social protection is essential to achieve gender equality and there is a strong link between the provision of public services and the ability of women to enter the labour market, to address unpaid care work responsibilities and to ensure that children have access to health and social services.

The push for the individualization of social protection has had a major impact on the delivery of these services, including on the provision of health and social care, pensions and unemployment benefits, to which austerity programmes have added perverse effects that lead to social exclusion or risk exposure – instead of inclusion and protection. The individual defined contribution pension schemes that the World Bank has been pushing for in Chile and in Eastern Europe in the 1990s are now coming to maturity. Trade unions have warned many times against those schemes, and our concerns have become reality since these schemes fail to deliver decent levels of pensions.

Genuine support for universal social security and healthcare could make important contributions to the achievement of decent work and reduced inequality. However, the international financial institutions (IFIs) continue to promote social protection reforms that focus on targeting, which is less efficient and more costly, rather than broad coverage. Also, investments by the World Bank in for-profit private healthcare through its private-sector arm, International Finance Corporation (IFC), are inconsistent with the objective of prioritizing universal health care rather than services for those able to pay for them.

Surveys in 89 countries, both low and high income, covering 89 percent of the world's population, suggest that 150 million people globally suffer financial catastrophe annually because they have to pay for health services.¹ Individual countries that have recently introduced universal coverage show that government investment results in better health outcomes. It is not the absolute percentage of GDP that determines health outcomes; it is how the healthcare is provided. For this reason, we also call for avoiding the promotion of public-private partnerships (PPPs)

for the provision of health care, as, owing to the need to guarantee a profit to the private partner, they usually end up costing governments more and reducing levels of benefits.

Reforms promoted by the World Bank, IFC and Regional Development Banks, including marketization, decentralization and corporatization of the public sector, provide opportunities for multinational companies to enter the public health care sector. Globally, international companies have won at least a quarter of contracts in health services and their influence on public health and social care systems is increasing rapidly. This has led to changes in the mix of different forms of health care financing, with some countries recording higher rates of out-of-pocket payments and a decline in the contribution of public health care expenditure in relation to overall health care expenditure.

In addition, public health spending is coming under increasing scrutiny across the world, particularly since the 2008-2009 global financial and economic crisis. In some European countries, large-scale cuts in public spending as well as public sector reforms were imposed by the so-called 'Troika' – European

1 WHO (2013).

Commission (EC), European Central Bank (ECB) and International Monetary Fund (IMF) – as a condition for financial rescue packages, as for example in Greece, Ireland and Portugal.

Austerity measures are not limited to Europe. Research into national IMF programmes shows that many adjustment measures are observed in developing countries and some even conclude that the IMF-driven effort to restore balanced budgets through fiscal austerity represents an immediate threat to global health.² While in the short run spending may fall, in the longer term these measures will work against the provision of an effective, integrated health system. Cuts in health spending have had devastating outcomes in some cases.

² Ortiz et al. (2015).

Cuts to public sector funding often penalize health workers and lead to reduced services at a time when demand for such services is increasing, as the economic crisis impacts on the wider economy. The main policy tools in the orthodox approach to health sector financing risk being counter-productive. Efforts to reduce costs by increasing competition have created fragmented structures that work against the integration and coordination of healthcare. Bringing in the private sector is likely to accentuate this silo mentality in provision, in the name of commercial confidentiality and profit maximization. Healthcare is not a commodity but a public good, and we want to see a strong commitment of government and IFIs alike to the implementation of the SDGs instead of pushing policies that deepen inequality and inequity.

References

- Ortiz, Isabel/Cummins, Matthew/Capaldo, Jeronim/Karunanethy, Kalaivani (2015): The decade of adjustment: A review of austerity trends 2010-2020 in 187 countries. ESS Working Paper No. 53. New York/Geneva: The South Centre/Initiative for Policy Dialogue, Colombia University/International Labour Office.
www.social-protection.org/gimi/gess/RessourcePDF.action?ressource.ressourceId=53192
- WHO (2013): The World Health Report 2013: Research for Universal Health Coverage. Geneva.
[www.searo.who.int/indonesia/documents/research-for-universal-health-coverage\(9789240690837_eng\).pdf?ua=1](http://www.searo.who.int/indonesia/documents/research-for-universal-health-coverage(9789240690837_eng).pdf?ua=1)

Sandra Vermuyten is Head of Campaigns at Public Services International (PSI)

system per 1,000 population” (indicator 3.8.2). This indicator clearly ignored the limitation of insurance to eliminate the financial risks involved in delivering health care. This indicator was changed due to protests from CSOs and academia in October 2016. The new indicator reads “Proportion of population with large household expenditures on health as a share of total household expenditure or income”.¹³

¹³ <https://unstats.un.org/sdgs/indicators/indicators-list/>.

WHO and undue corporate influence

The WHO constitution mandates the organization to set norms and standards in the area of health and to provide technical assistance to Member States to implement those norms and standards. Therefore WHO has a major role in assisting its Member States to achieve SDG 3. However, WHO is suffering from certain structural constraints on its ability to insulate itself from undue influence, especially from the foundations and corporations and corporate interests backed by some Member States.

First, the financing of WHO, as with the entire UN system, has over time shifted from assessed contributions to specified voluntary contributions.

For the 2016-17 biennium approximately 80 percent of WHO's budget is financed through specified voluntary contributions.¹⁴ Unlike assessed contributions and core voluntary contributions, specified voluntary contributions have little flexibility for WHO to use the funds to address health priorities. The reliance on voluntary contributions thus leads WHO to become a donor-driven organization rather than a membership-driven organization.

Of total financial contributions for the biennium 2016-17 philanthropic foundations contributed 13.9 percent, NGOs 4.9 percent, partnerships 4.4 percent, and corporations 1 percent.¹⁵ The voluntary contribution of the Bill & Melinda Gates Foundation positioned it as WHO's largest voluntary donor in 2016-2017.

Even though on the surface the corporations contribute minimally, their influence on WHO is multiplied as a result of the political patronage from large donor countries such as the USA and the UK as well as from private donors including philanthropic foundations such as the Bill & Melinda Gates Foundation and various professional bodies that provide funding.

Second, WHO lacks the framework to comprehensively address undue influence especially with regard to conflict of interest. The organization does not have a comprehensive conflict of interest policy to address both individual and institutional conflict of interest. Even though WHO's Framework of Engagement with Non-State actors (FENSA) adopted in 2016 does mention conflict of interests, it does not provide any details with regard to avoidance and management of such conflict.¹⁶

Another area of conflict of interest is emanating from the participation of individual experts in various norm-setting activities. The guideline by which to assess the declaration of interest states that receiving a sum of US\$ 5,000 from a pharmaceutical company in a calendar year does not constitute a serious conflict. In other words, it means when an expert receives US\$ 5,000 each from several pharmaceutical companies, this does not result in serious conflict.

Third, there is undue corporate influence over WHO's norms and standards setting activities. WHO's participation in the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH), a standard-setting body on medicines whose Secretariat is at the Office of the International Federation of Pharmaceutical Manufacturing Associations (IFPMA) leads to the so-called 'higher' standards adversely affecting the generic industry.¹⁷ For example, the WHO standard on biosimilars is heavily drawn from the ICH standard that reduces competition in the biosimilar market and thus affects affordable access to bio-therapeutics.

Recently, the WHO Essential Medicines and Health Products Department has engaged organizations linked to the pharmaceutical industry to draft and consult on a guideline on Good Regulatory Practice (GRP) for national medical products regulatory authorities. It transpired that one of the drafters, Mr. Michael Gropp, is former Vice President of Global Regulatory Strategy in Medtronic, a multinational corporation. According to the Stanford Byer Centre for Biodesign, Stanford University, "Mr. Gropp retired from his corporate position in May 2013. He continues to chair the Global Advisory Council of Regulatory Affairs Professionals Society" (RAPS), a society whose entrepreneur membership includes global pharmaceutical giants such as Abbott, Gilead Sciences, Pfizer, Astra Zeneca, Novartis and Eli Lilly among others.¹⁸

Fourth, the collaborative work plans between the WHO Secretariat and NGOs, a requirement for offi-

14 <http://open.who.int/2016-17/contributors> (figures updated until Q1 2017).

15 <http://open.who.int/2016-17/budget-and-financing>.

16 www.who.int/about/collaborations/non-state-actors/en/.

17 Nagarajan (2014).

18 <http://twn.my/title2/health.info/2016/hi160507.htm>.

cial relations with WHO, often lead to the promotion of business interests. For instance, the joint work programme between the Global Medical Technology Alliance and WHO as part of the documentation for the consideration of the Standing Committee on NGOs states among its objectives:

“Promote the safe use of medical devices through compiling and distributing materials and training on the safe use and proper disposal of medical devices for healthcare professionals, through the Alliance member associations.”¹⁹

This implies that a trade association would work with the WHO to promote the use of medical devices through compiling and distributing materials, which would clearly result in economic benefits to the members of the association. It could also result in the unnecessary promotion of the use of medical devices without adequate evidence and put commercial interests above public health. Similarly, conflict of interests can be found in the collaborative work plan of Global Diagnostic Imaging, Healthcare IT and the Radiation Therapy Trade Association.²⁰

Fifth, discrepancies in the implementation of FENSA undermine the minimum safeguards against undue corporate influence over WHO during its engagement with non-State actors, largely because of the discretion it gives to the WHO Secretariat. Even though FENSA facilitates the engagement with non-State actors, it brings a greater degree of transparency with regard to the entities concerned. Further, FENSA prohibits staff secondment from the private sector. It also prohibits financial resources from the private sector for norms and standard setting activities.

However, there are concerns that the great degree of discretion given to the WHO Secretariat for the implementation of FENSA enables the Secretariat to use this discretion to implement FENSA in a manner that is not true to the spirit of the framework. For instance, the Secretariat in contravention of FENSA provisions did not provide to Member States details of

the collaborative work plans of some non-State actors that sought official relations with WHO. This prevented Member States from taking an informed decision with regard to the official relation status of the Bill & Melinda Gates Foundation.

According to FENSA an entity that cannot be shown to be “at arm’s length” from the private sector is considered as private sector irrespective of its legal status.²¹ Private sector entities are not eligible for official status. Approximately one-quarter of the Gates Foundation Trust assets are invested in Berkshire Hathaway Inc., a holding company that owns an approximately US\$ 18 billion share in the US-based Coca-Cola company and US\$ 30 billion interest in Kraft Heinz Inc., two of the world’s ten largest food and beverages companies (as of June 2017). Moreover, the 2015 tax returns of the Trust show it holds shares and corporate bonds in pharmaceutical companies such as Pfizer (US\$ 719,462 base market value), Novartis AG-REG (US\$ 6,920,761), Gilead Sciences (US\$ 2,920,011 base market value), GlaxoSmith-Kline (US\$ 1,589,576 base market value), BASF (US\$ 4,909,767), Abbott Laboratories (US\$ 507,483), Roche (US\$ 7,760,738), Novo Nordisk A/S B (US\$ 6,208,992), Merck (US\$ 782,994). Tax returns also reveal that the Trust has investments in major insurance companies.²² Since the Gates Foundation earns its revenue from the Trust, and both entities are managed by the same set of people, there is no arm’s length between the Trust and the Foundation which should not therefore have been granted official relations status.

Meanwhile, the World Health Assembly Resolution 69.10, which adopted FENSA, prohibits staff secondment from NGOs, academia and philanthropic foundations in the top management and sensitive posts. In a document tabled to Member States at the May 2017 World Health Assembly, the WHO Secretariat changed the words “sensitive posts” to “validation and approval of norms and standard setting”. If this is accepted, secondments would be possible even for the preparation of norms and standard settings.

19 http://apps.who.int/gb/NGO/pdf/B136_NGO_11-en.pdf.

20 http://apps.who.int/gb/NGO/pdf/B136_NGO_12-en.pdf.

21 WHO Doc. Resolution WHA69.10, p. 7.

22 www.gatesfoundation.org/Who-We-Are/General-Information/Financials.

Finally, there is also a conflict of interests with regard to the implementation of FENSA. The director in charge of FENSA implementation is at the same time in charge of resource mobilization and partnerships, in conflict with its gatekeeper role to regulate non-State actor engagement.

Conclusion

In light of the above discussion, it is clear that most partnerships freely allow the participation of the private sector, especially big corporations. In the absence of a clear framework to avoid undue influence, these partnerships could be used to pursue corporate interests while projecting themselves as initiatives for the achievement of SDGs. Since SDG 17 does not contain any safeguards against undue influence from the corporate sector in implementing the goals it is important to advocate for such a framework.

In addition, WHO, which is an important agency to provide assistance to Member States for the implementation of SDGs, suffers from structural problems that increase its vulnerability to corporate influence at the costs of public health and public interest. Even though FENSA places some restrictions on engagement with non-State actors, especially the private sector, there are landmines in the Secretariat's implementation of FENSA. Therefore explicit safeguards and constant vigilant monitoring and advocacy against corporate influence are necessary.

References

- Goldman, Andrew and Balasubramaniam, Thiru (2015):** Switzerland pressures Colombia to deny compulsory license on imatinib. In: Knowledge Ecology International, 18 August 2015. <http://keionline.org/node/2312>
- Médecins Sans Frontières (2015):** The Right Shot: Bringing Down Barriers to Affordable and Adapted Vaccines. Second Edition. Geneva. www.msfaaccess.org/sites/default/files/MSF_assets/Vaccines/Docs/VAC_report_TheRightShot2ndEd_ENG_2015.pdf
- Nagarajan, Rema (2014):** Conflict of interest in setting norms for pharmaceuticals in WHO. In: Times of India, 17 May 2014. <http://timesofindia.indiatimes.com/city/delhi/Conflict-of-interest-in-setting-norms-for-pharmaceuticals-in-WHO/articleshow/35261958.cms>

K M Gopakumar is Legal Advisor and Senior Researcher with the Third World Network (TWN)