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GOVERNANCE FOR HEALTH

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This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

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INTRODUCTION

The conceptual framework for action on the social determinants of health of the World Health Organization (WHO) recognized 'governance' as one of the main components that shape the socioeconomic and political context that, in turn, determines the socioeconomic position of individuals and communities and thus their access to conditions for health (Solar & Irwin 2010). Major components of governance, including influential actors (decision-makers) and decision-making processes and procedures, change over time following a change in the nature of societies and governing bodies and change in dominant ideologies, dominant economic policies, and power dynamics (Kickbusch & Gleiche, 2012; Bennett et al. 2012). During the last few decades, governance for health changed from state-driven decision-making dominated by governments and using constitutional and legislative platforms at the country level and multilateral organizations at the international level to multi-stakeholder decision-making. Those stakeholders included market disciplines and corporations representing the domination of neoliberal economic policies. The change in governance for health was also associated with a more significant role for monetary institutions like the International Monetary Fund (IMF) and the World Bank (WB) over the United Nations specialized health organization, WHO. At the national level, ministries of finance gained greater influence on health policies than ministries of health – here, referring to health policies in a broader sense and not just health budgets.

The current paper is an attempt to highlight the linkage between governance for health and the change in dominant economic policies during the last five decades. It will also provide definitions and identify the influential actors in global and national health decisions and discuss how they practice their influence. The analysis in this paper is supported by some case studies from the Arab region.

DEFINITIONS

Governance refers to actions and processes formally adopted or informally used to rule decision-making over common goods. Formally adopted decision-making processes or procedures are usually embedded in constitutions of multilateral organizations, international treaties, or national or local constitutions and legislation. Informal governance includes uncodified, non-institutional means of decision-making where power relationships and dynamics would determine the final decisions or influence the course of negotiations. This definition focuses mainly on the process rather than the goals or outcomes of the governance.

To highlight the process, goals, and values of governance, governance can also be defined as the rules and procedures for managing resources, making decisions, and structuring accountability. It applies to a country, institution, or group of people (Center to Eliminate Health Disparities (CEHD) 2016); or structures, policies, norms, and processes designed to ensure accountability and transparency (Atiku 2019).

Governance for Health refers to actions and processes adopted to promote and protect people's health. With this definition, these actions and processes are directly or indirectly linked or have the capacity to influence health determinants, status, and outcomes (Garson & Khosrow-Pour 2008). This definition incorporates decision-making processes in non-health sectors or domains that may directly or indirectly influence people's health, including but not limited to policy, economy, trade, education, urban development, and immigration.

The World Health Organization (WHO) recognizes two components of the governance for health (Kickbusch & Gleiche 2012):

1. Health system governance in terms of existing policy frameworks and processes and procedures for oversight, coalition-building, regulation, system design, and accountability. In this component, WHO recognized three stakeholders (World Health Organization 1978):
    - The State, represented by central and sub-national authorities and governmental organizations;

- The health service providers, including public, private, and not-for-profit clinical, para-medical, and non-clinical health services providers; professional associations; networks of care or services); and
- The citizen, including population/community representatives, patients' associations, community-based organizations (CSOs), non-governmental organizations (NGOs)

2. Joint actions of health and non-health sectors to address health determinants (Kickbusch & Gleiche 2012).

   This definition focuses on the interaction among users, providers, and regulators of healthcare services in addition to joint actions between health and non-health sectors while ignoring the influence of international bodies, including multilateral organizations, agencies affiliated with other governments, and international donors. It also failed to recognize the role of power structures that shape the decision-making process at national and sub-national levels.

MILESTONES IN HEALTH DEVELOPMENT AND DECISION-MAKING

THE WORLD HEALTH ORGANIZATION (WHO) CONSTITUTION (1946-48)

Entered into force on April 7th, 1948, the World Health Organization (WHO) constitution defined health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (United Nations 1946). This revolutionary definition of health untied health from the provision of healthcare services, though it is one of the key determinants, and indicated the necessity of multidisciplinary effort and multisectoral collaboration.

In its preamble, the constitution considered that "*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition*" and "*governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures*" (United Nations 1946). The recognition of health as a fundamental human right means that there is a right-holder and duty bearer. Every human being is a right-holder for their health and is entitled to the State as a duty-bearer, with no discrimination. This recognition provides a tool for progressive civil society groups to advocate for people's right to health. It may also suggest that the action agenda of these groups should include the following:

1. empowering individuals and communities to claim their right to health;
2. advocating for clear provisions in the national and local constitutions and legislation to protect the right to health before the law, defining means to realize this right (including adequate financial resources), and defining procedures individuals and groups can use to claim their rights; and
3. building the capacity of state authorities and organizations to fulfill their duties to protect the right to health, including creating conditions of health and providing health and social interventions.

In terms of governance for health at national and local levels, the WHO constitution considers States as the duty bearer of people's right to health. This means that States, not stakeholders, are responsible for the decision-making and provision of adequate measures to fulfill this right. The State may involve other actors in supporting the decision-making process, informing a proper planning process, or providing health and health-related services. However, these non-state actors are not decision-makers, and they are not duty-bearers.

Regarding governance at the global level, article 2 of the constitution requires WHO "*to act as the directing and coordinating authority on international health work*" (United Nations 1946). The same article also mandates that the WHO "*establish and maintain effective collaboration with other UN organizations, governmental health administrations, and professional groups.*" The constitution clearly considers WHO the directing and coordinating authority for global health, not one of the multiple stakeholders.

In conclusion, the WHO constitution considers governments at national and local levels and WHO at the international level as the authorities and coordinating bodies for health. It does not recognize the concept of a multi-stakeholder decision-making modality.

THE DECLARATION OF ALMA ATA (1978)

The Declaration of Alma-Ata was adopted by 134 countries at the end of the International Conference on Primary Health Care held in Kazakhstan, one of the Soviet Union republics (6 - 12 September 1978), sponsored by WHO and UNICEF. The Declaration is one of the major public health milestones of the twentieth century. The Declaration affirmed the WHO constitution's definition of health and the recognition of health as a fundamental human right. It emphasized the principles of universal accessibility and coverage based on need (equity), comprehensive care (promotional, preventive, curative, and rehabilitative care), community and individual involvement and self-reliance, the intersectoral action for health, and the appropriate technology and cost-effectiveness in relation to available resources. It adopted Primary Health Care (PHC) as an essential tool to achieve health for all (World Health Organization 1978).

The Declaration stated the need for a "*New International Economic Order*" to realize health for all and achieve equity between developed and developing nations (World Health Organization 1978). This statement provided a solid basis for

dealing with health governance as a sub-domain of political and economic governance at international and national levels. This assumption is aligned with understanding health as an outcome of the interaction between biological factors and social, economic, political, and environmental determinants. It is worth noting that the Declaration of Alma Ata was adopted within the context of the Cold War, the oil price crisis that followed the 1973 Arab-Israeli war, and it was only possible with the leadership of Dr. Hafdan Mahler, the Director-General of WHO at that time (Cueto 2004).

At the national level, the Alma Ata Declaration reaffirmed the central role of governments by giving them full responsibility for the health of their people. Globally, the Declaration considered health for all peoples of the world a shared responsibility between governmental and international organizations and the international community (Exworthy 2008).

In conclusion, the Declaration of Alma Ata consolidated the social model of health (Exworthy 2008), provided a solid basis for health governance as a sub-domain of political and economic governance, and innovated the notion of collective responsibility of governments, international multilateral institutions, and the international community at large to achieve health for all peoples of the world by 2000 as a social target (World Health Organization 1978).

SELECTIVE PRIMARY HEALTH CARE (1979)

One year after the vast adoption of the Declaration of Amla Ata, two researchers from the United States, Julia Walsh and Kenneth Warren, backed by the Rockefeller Foundation, published an article in the New England Journal of Medicine titled “Selective Primary Health Care — An Interim Strategy for Disease Control in Developing Countries” (Walsh & Warren 1979). The article argued that comprehensive PHC, as articulated in the Declaration of Alma Ata, is costly to implement and that there is a need for an interim strategy that is feasible for the majority of developing countries. Their suggested interim strategy included four interventions focusing on children: growth monitoring, oral rehydration, breastfeeding, and immunization. These interventions were selected based on an analysis of the leading causes of death in early childhood. Later, three more interventions were added to the list, including family planning, food supplements, and female education.

During the same year, the Rockefeller Foundation sponsored a small meeting on its premises in Bellagio, Italy, to discuss what they considered to be the crisis to Alma Ata Declaration

(i.e., being too broad, idealistic, costly to implement, and unrealistic to achieve by 2000). The meeting organizers included the leaders of Western, mainly North American-based organizations and donor agencies, as well as the World Bank (Cueto 2004).

The four 'selective' interventions appealed to donors as they are easy to monitor and evaluate, measurable, and have numerical targets. The international monetary institutions, especially the World Bank, and the big Western donors used this argument to adopt, fund, and promote this strategy among developing countries. The Selective Primary Health Care (SPHC) approach led to donor-driven, donor-dependent, vertical, and non-sustainable programs in developing countries (Obimbo 2003). For example, the coverage of immunization programs in Kenya fell from 60% in 1987 to 32% in 1997 when donors withdrew their financial support (Obimbo 2003).

The Rockefeller-hosted meeting in Bellagio sought to examine the potential for a decision-making process in global health that does not use the platforms offered by the UN. The movement of the SPHC introduced a gradual change to the landscape of global governance for health with a growing role of Western donors in driving the health system agendas in developing countries and the weakening role of the WHO.

THE WASHINGTON CONSENSUS AND STRUCTURAL ADJUSTMENT PROGRAMS (1990S)

The Washington Consensus refers to a set of ten market economy principles presented initially by John Williamson in 1989, which gained wide adoption by prominent economists who are supportive of market economy ideas, big powers (the United States and European Union), and monetary institutes (the World Bank and the International Monetary Fund) (Pettinger 2017). The ten principles were low government borrowing, redirection of public spending, tax reform to broaden the tax base, market-determined interest rates, competitive exchange rates, trade liberalization, openness to direct foreign investment, privatization, deregulation, and secure property rights (Rodrik 2006). Since the 1990s, international financial institutions have been providing low-interest loans to developing countries with conditions of implementing the principles of the Washington Consensus, known as structural adjustment programs (SAPs). In the health sector, SAPs translated into the following health sector reform (HSR) policies:

- Withdrawal of the State from health service provision;
- Reduction of health spending and adopting a low-cost, basic package of interventions;
- Decentralization; and
- Mobilization of multiple sources for healthcare financing.

These measures reinforced the bio-medical oriented, curative, and selective approach to healthcare and initiated a massive wave of privatization. Studies have shown that SAPs policies have slowed down improvements in, or worsened, the health status of people in countries implementing them through, for example (Loewenson 1993):

- Worsening of nutritional status of children;
- Increased incidence of infectious diseases; and
- Higher infant and maternal mortality rates.

SAPs have further consolidated the domination of global governance for health by rich countries (primarily the United States and the European Union) and affiliated financing mechanisms or donors. At the country level, they concentrated the decision-making power in finance rather than health ministries.

The Impact of SAPs: The Case of Sudan

In 1992, the government of Sudan (before it was divided into Sudan and South Sudan) adopted major structural economic reforms under the name of 'liberalization policies.' The impact of these reforms on the health sector was reported in several areas:

- **Decreased healthcare financing:** Governmental spending on health services declined by 83% in seven years from 1.4 Sudanese pounds (SPG.) per capita in 1986/87 to 0.24 SPG in 1993/94. This severe decline was not justified by the limitation of financial resources as the general domestic product increased by 21.6% in the same period (Babiker 1996). The reduction of public health spending and gradual withdrawal from the health (and social) services provision was aligned with standard measures of the International Monetary Fund (IMF) and the World Bank (WB) at that time. They were also favorable to the political priorities of Sudan during the war in the south of the country in the early 1990s.

- **Introduction of a user fee at the time of service:** In the early 1990s, the Sudanese government implemented some "closing the gap" measures in healthcare financing associated with the reduction of public spending. It innovated the 'self-help system.' A change from the dominant free health services system before the 1990s to a 'cost-sharing' system under which the public facilities began to collect higher fees at the time of health service provision in outpatient and inpatient settings. The 'self-help system' was followed by presenting the 'economical treatment' program in selected healthcare centers in Khartoum. The healthcare services provided by these selected centers were considered upgraded services compared with those offered by regular public facilities. The fees were mid-way between the 'self-help' fees at the regular public healthcare facilities and the cost of private facilities (OSSREA 1999).

  The two models of collecting fees from users at the time of service provision were presented under the name of 'promotion of healthcare services,' which attributed the deterioration of healthcare services in the country to the lack of financial resources and the overuse of services. The government justified the direct fee-for-services as one of the measures to regulate the utilization of healthcare services and secure financial resources to improve their quality.

- **Decreased access and utilization of public healthcare services:** This period in Sudan witnessed a high burden of infectious disease and malnutrition due to low living standards, poverty, and the consequences of the war in Southern Sudan (UNICEF 1996). Despite the high disease burden, the utilization of public healthcare declined. A study by the Organization for Social Science Research in Eastern and Southern Africa (OSSREA) attributed this decline to the increase in the cost of public healthcare services associated with deterioration in the quality of care which directed users to the private healthcare sector (OSSREA 1999).

> Governance-wise, the 'health sector reform' in the early 1990s in Sudan was a sub-domain of economic liberalization and was informed by the liberalization agenda of the IMF/WB and the military agenda of the government of Sudan rather than responding to a well-studied reform based on systematically assessed needs.

GLOBAL INITIATIVES (1990s AND 2000s)

In the 1990s through the 2000s, more than 100 global financial mechanisms were established to fund different aspects of health development. This resulted in the following features:

- **Donor-driven priorities:** Further fragmentation of health systems at the national level (more vertical programs).
- **Financial mess:** Excessive demand on government time and loyalty to donors.
- **Concentration of health personnel in funded projects:** Neglected places and neglected areas of healthcare.
- **Creating dependency:** No serious sustainability plan.

In addition to the international monetary institutions and governmental organizations affiliated with rich countries (primarily the United States and European Union), the global initiatives consolidated the role of transnational corporations and business fronts as key players in global health decision-making. This was natural since the majority of these financing mechanisms were heavily funded by corporations or private foundations.

The Case of the Child Survival Project in Egypt

In the early 1980s, the U.S. Agency for International Development (USAID) developed a donor strategy for child survival in Egypt (Tumavick et al. 1990). While describing it as a donor strategy, the donor, USAID, reported that the strategy was developed in collaboration with the Government of Egypt, the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO). The project adopted two interventions: (1) Extensive use of oral rehydration therapy (ORT) to limit the severe consequences of childhood diarrhea, and (2) Expanding the childhood immunization program against six communicable diseases (tuberculosis, diphtheria, pertussis, tetanus, polio, and measles).

The Child Survival Project is a demonstrative example of a vertical program that follows the notion of SPHC that was widely adopted by Western donors. The use of ORT continues to be a cost-effective best practice in the initial management of diarrhea among children under five years (Mosegui et al. 2019). However, it deals with the disease (diarrhea) when it occurs and does not address the causes or the risk factors of the disease; that is, ORT reduces the incidence of diarrhea but only treats it after it occurs. National surveys concluded a positive change in the awareness of the importance of ORT, while the national statistics showed a decline in infant mortality. A formal USAID report claimed that both changes were due to the National Control of Diarrheal Diseases project (NCDDP) in Egypt (Tumavick et al. 1990). The same report indicated that there was no evidence of a decline in the severity of diarrheal attacks in infants and children or a decrease in prevalence of cases of dehydration attributed to NCDDP. In other words, available data at this time could not establish evidence on the role of NCDDP in decreasing the prevalence nor the severity of dehydration cases. In addition, data available at this time did not indicate any significant impact of the NCDDP on the incidence of diarrhea among infants and children. It is likely because the NCDDP does not address the root causes of the disease, e.g., access to safe drinking water and a proper sanitation system.

Werner and Sanders (1997) compared comprehensive primary healthcare versus selective primary healthcare in child diarrhea in their book, "Questioning the Solution: The Politics of Primary Health Care and Child Survival (with an in-depth critique of Oral Rehydration Therapy)" (Werner & Sanders 1997). It clearly showed the limitation of selective primary healthcare in affecting the occurrence of diarrhea or assisting with improving child outcomes by only adopting selective curative approach.

Table 1. Comprehensive versus selective primary health care in addressing diarrhea in children

Rehabilitative	Curative	Preventive	Promotive
Nutrition Rehabilitation	ORT	Education for personal & food hygiene	Water
	Nutrition support	Measles vaccination	Sanitation
		Breastfeeding	Household food security

Source: Werner & Sanders, 1997

WHO MAKES HEALTH DECISIONS?

THE MOVE FROM STATE-CONTROLLED GOVERNANCE TO MULTI-STAKEHOLDERS (STAKEHOLDERIZATION)

As described in the previous section, during the last four decades, global governance for health has been changed from the domination of United Nations specialized organizations, especially WHO and partially UNICEF, UNDP, UNFPA, UNAIDS, etc. to the domination of Bretton Woods Institutions (International Monetary Fund, World Bank, and World Trade Organization) to the domination of transnational corporations and private foundations (e.g., Bill and Melinda Gates Foundation), as demonstrated in **Figure 1** below.

SOURCES OF WHO FUNDING

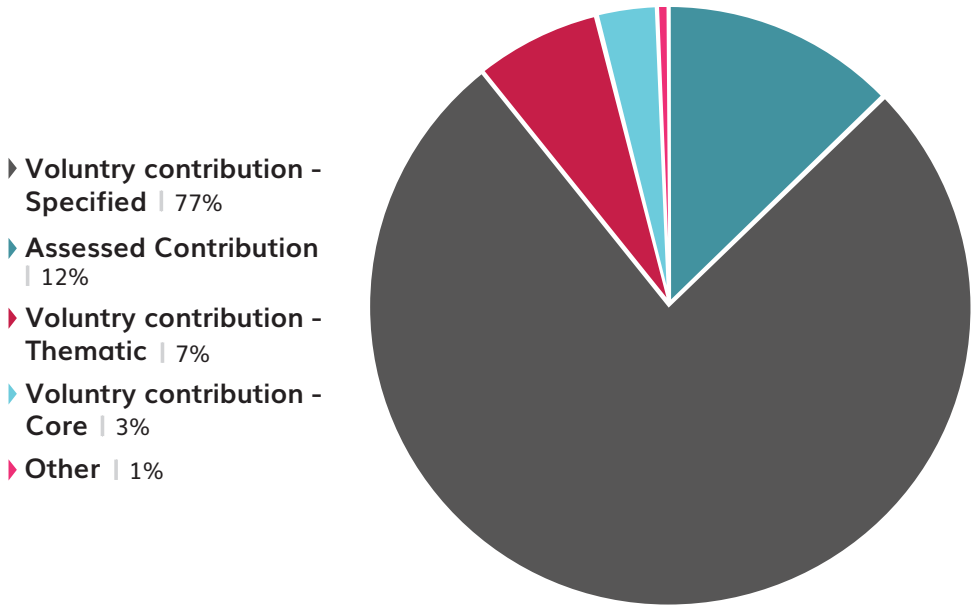
In addition to its immense underfunding, WHO faces four crises in relation to its financing. It suffers misalignment between program budgets and financial commitments from member states, financial unpredictability, lack of transparency in financing and distribution of available funding, and inefficiency in managing the available financial resources (Reddy et al. 2018). To put this in context, the total WHO program budget in 2020-2021 was less than 7.6 billion, which is less than one-fifth of the healthcare budget of the State of Texas, USA, for the same fiscal year (Texas Health and Human Services 2021). Sources of WHO funding can be categorized as:

- Assessed contributions are a percentage of a country's gross domestic product (the percentage is agreed upon by the United Nations General Assembly). Member States approve them every two years at the World Health Assembly.
- Voluntary contributions are largely from Member States as well as from other United Nations organizations, intergovernmental organizations, philanthropic foundations, the private sector, and other sources.

In the WHO budget for 2020-2021, the assessed contribution accounted only for 12% of the total budget, while voluntary contributions represented 87% (refer to Figure 1). The WHO's dependence on voluntary contributions enables external donors

to dictate the WHO's institutional priorities and action agendas (Reddy et al. 2018). **Table 2** and **Table 3** show the impact of voluntary contributions on re-orienting the WHO priorities. One of the clear examples is how the generous funding of the Bill and Melinda Gates Foundation to polio eradication made polio eradication a second priority of WHO even during the COVID-19 pandemic.

Figure 1. World Health Organization revenue by type, 2020-2021



Source: WHO, Contributions 2020-2021: Funding by Contributor. Link.

Table 2. Distribution of the voluntary contribution of Bill & Melinda Gates Foundation

Program	%	Program	%
Polio eradication	**64.37%**	Reduced number of people suffering from financial hardship	0.55%
Improved access to quality essential health services	13.43%	Financial, human and administrative resources managed in an efficient, effective, result-oriented and transparent manner	**0.50%**
Strengthened country capacity in data and innovation	**5.92%**	Strengthened leadership, governance and advocacy for health	0.48%
Improved access to essential medicines, vaccines, diagnostics and devices for primary health care	5.21%	Health emergencies rapidly detected and responded to	0.19%
Endemics and pandemics prevented	3.14%	Proven prevention strategies for priority pandemics / epidemic-prone diseases implemented at scale	0.17%
Acute health emergencies rapidly responded to, leveraging relevant national capacities	2.47%	Health settings and health in all policies promoted	0.15%
Special program of research, development and research training in human reproduction	0.86%	Countries prepared for health emergencies	0.03%
Risk factors reduced through multisectoral action	0.85%	Countries operationally ready to assess and manage identified risks and vulnerabilities	0.03%
Social determinants of health	0.84%	Fast tracked delivery for pandemic-causing pathogens	**0.01%**
Special program for research and training in tropical diseases	0.80%		

Source: WHO Official Program Budget Portal

Table 3. Distribution of WHO overall budget

Program	%	Program	%
Acute health emergencies rapidly responded to, leveraging relevant national capacities	**40.52%**	**Social determinants of health**	**1.47%**
Polio eradication and transition plans implemented in partnership with the global polio eradication initiative	15.56%	Countries operationally ready to assess and manage identified risks and vulnerabilities	1.38%
Improved access to quality essential health services	**14.82%**	Risk factors reduced through multisectoral action	1.22%
Epidemics and pandemics prevented	5.14%	Strengthened leadership, governance and advocacy for health	1.18%
Proven prevention strategies for priority pandemics / epidemic-prone diseases implemented at scale	3.61%	Reduced number of people suffering from financial hardship	0.85%
Improved access to essential medicines, vaccines, diagnostics and devices for primary health care	3.34%	Fast tracked delivery for pandemic-causing pathogens	0.75%
Health emergencies rapidly detected and responded to	2.48%	Special program for research and training in tropical diseases	0.68%
Strengthened country capacity in data and innovation	2.17%	**Financial, human and administrative resources managed in an efficient, effective, result-oriented and transparent manner**	**0.41%**
Countries prepared for health emergencies	2.14%	**Health settings and health in all policies promoted**	**0.39%**
Special program of research, development and research training in human reproduction	1.52%	**Pandemic influenza preparedness framework**	**0.39%**

Source: WHO Official Program Budget Portal

THE CURRENT GOVERNANCE STRUCTURES FOR GLOBAL HEALTH AND THE CHANNELS THROUGH WHICH THEY INFLUENCE DECISION MAKING

Legge (Legge 2023) recognized six categories of actors in global governance for health:

1. Multilateral organizations and international treaties (U.N. system – WHO, UNICEF, UNDP, UNAIDS, ECOSOC; Bretton Woods system – IMF and WB; trade agreements, etc.)
2. Inter-governmental bodies and big powers (G8, G20, OECD, E.U., U.S.A., etc)
3. Transnational corporations (big pharma and food industry)
4. Market disciplines (demand and supply and how it applies in health)
5. Social movements
6. Knowledge flow

TRANSNATIONAL CORPORATIONS (T.N.C.S)

Transnational organizations have been growing in size, increasing in number, and carrying an increasing proportion of global trade. They play a dominant role in mobilizing funds and technologies for investment. For example, the role of big pharmaceuticals in global governance for health is a good example of the growing influential role of corporations in governance for health at both global and national levels. The story of the interaction between the Egyptian government and Gilead is an illustrative example, and is described below.

Back to 2015: The Case of Hepatitis C and Big Pharmaceuticals in Egypt

Despite the recent and ongoing advancements in curative treatments for Hepatitis C Virus (HCV), access to the antiviral treatment remains limited in Egypt. In 2008, the National Committee for the Control of Viral Hepatitis (NCCVH) published a 5-year strategy (2008-2012). It estimated that in 2008 the number of HCV patients who would be eligible for antiviral treatment was 600,000 (Dalglish 2008). However, from 2008-2011, only 190,000

patients received the treatment. The number of patients receiving treatment was 22,000 in 2008, increased to 65,000 in 2009 and then declined gradually to 58,000 and 45,000 in 2010 and 2011, respectively (Centers for Disease Control and Prevention 2012). In a more recent survey, 38% of HCV patients between 15-59 years in a nationally representative sample self-reported receiving HCV antiviral treatment. The percentage was 29.7% for women and 41.7% for men. However, the majority of them self-reported receiving the old treatment regime (interferon) with a 51% cure rate while only 4.8% reported receiving new antiviral medicines (Sofosbuvir or Olysio) with a 79-96% cure rate (Ministry of Health and Population, Egypt 2015).

The strategy, which the Egyptian health authorities continue to follow, tied expanding the access of HCV antiviral treatment to the distribution of a relatively low-priced course of the antiviral treatment through governmental medical facilities based on strict guidelines. During the last decade, the Egyptian government has repeatedly adopted the approach of negotiating with pharmaceutical companies for a reduced price-HCV antiviral treatment for use within the public sector. For example, in 2008, the government reached an agreement with two transnational pharmaceutical companies (Merck and Roche) to produce locally-packed Pegylated Interferon at US$2,000 (to be paid by the patients) instead of US$12,000 (the international price) for a 48-week treatment course (as cited in Kaplan and Swan 2012). The reduced price represented 47% of the average annual Egyptian family income and 56% of the annual income of rural households in the fiscal year 2010-2011.

In 2014, the Egyptian Government repeated a similar deal with Gilead Sciences (a US-based pharmaceutical company) to purchase a preparation of Simeprevir (as a part of the currently recommended triple therapy) at US$900 (to be paid by the patients) instead of US$84,000 (the original price in the US market) (Fick & Hirschler 2014). This significant reduction in the cost was not reflected in a corresponding expansion of the HCV treatment coverage. This suggests that cost is still beyond the affordability of patients and/or there are

a broader range of barriers (Dalglish 2012; Ministry of Health and Population, Egypt 2015). Such uncertainties reflect a knowledge gap in identifying the barriers to HCV antiviral treatment and/or the ability of the limited existing knowledge to guide an informed decision making process.

CONCLUSION

Governance for health is a sub-domain of economic governance. As the case studies in this report demonstrated, the domination of neoliberal policies, financialization of the economy, and stakeholderization have influenced the governance structure for health. This paper also provided some definitions and an overview of some of the financing mechanisms for health.

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