

# Global Health Governance

## *A CONCEPTUAL REVIEW*

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## **Preface**

WHO's work in the area of Globalization and Health focuses on assisting countries to assess and act on cross border risks to public health security. Recognising that domestic action alone is not sufficient to ensure health locally the work programme also supports necessary collective action to address cross border risks and improve health outcomes.

In carrying out this work there was an increasing recognition that the existing rules, institutional mechanisms and forms of organization need to evolve to better respond to the emerging challenges of globalization and ensure that globalization benefits those currently left behind in the development process.

Consequently, as part of WHO's research programme on Globalization and Health, global governance for health was identified as an issue that required more detailed analysis to better inform policy makers interested in shaping the future "architecture" for global health.

Working in partnership with the Centre on Global Change and Health at the London School of Hygiene and Tropical Medicine, WHO's Department of Health and Development commissioned a series of discussion papers as a starting point to explore the different dimensions of global governance for health. The papers have been written from varying disciplinary perspectives including international relations, international law, history and public health. We hope these papers will stimulate interest in the central importance of global health governance, and encourage reflection and debate among all those concerned with building a more inclusive and "healthier" form of globalization.

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## ABBREVIATIONS

<b>EBF</b>	extrabudgetary funds
<b>FCTC</b>	Framework Convention on Tobacco Control
<b>GATT</b>	General Agreement on Tariffs and Trade
<b>GHG</b>	global health governance
<b>GPPPs</b>	global public-private partnerships
<b>HSD</b>	Department of Health and Sustainable Development (WHO)
<b>ICPD</b>	International Conference on Population and Development
<b>IFPMA</b>	International Federation of Pharmaceutical Manufacturers Associations
<b>IGO</b>	intergovernmental organization
<b>IHG</b>	international health governance
<b>IHR</b>	International Health Regulations
<b>IMF</b>	International Monetary Fund
<b>IR</b>	International Relations
<b>MSF</b>	Medicins Sans Frontieres
<b>NGO</b>	nongovernmental organization
<b>OECD</b>	Organization for Economic Cooperation and Development
<b>OIHP</b>	Organization Internationale d'Hygiène Publique
<b>PAHO</b>	Pan American Health Organization
<b>PASB</b>	Pan American Sanitary Bureau
<b>SAP</b>	structural adjustment programme
<b>SPS</b>	Sanitary and Phytosanitary Measures
<b>TBT</b>	technical barriers to trade
<b>TFI</b>	Tobacco Free Initiative
<b>TNC</b>	transnational corporation
<b>TRIPS</b>	agreement on Trade-Related Intellectual Property Rights
<b>UNDDSMS</b>	United Nations Department for Development Support and Management Services
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>UNICEF</b>	United Nations International Children's Emergency Fund/UN Children's Fund
<b>UNRRA</b>	United Nations Relief and Rehabilitation Administration
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization
<b>WTO</b>	World Trade Organization

## GLOBAL HEALTH GOVERNANCE, A CONCEPTUAL REVIEW

*The solution lies not in turning one's back on globalization, but in learning how to manage it. In other words, there is a crying need for better global governance...*

UN Deputy Secretary-General Louise Frechette (1998)

*...global governance cannot replace the need for good governance in national societies; in fact, in the absence of quality local governance, global and regional arrangements are bound to fail or will have only limited effectiveness. In a way, governance has to be built from the ground up and then linked back to the local conditions.*

R. Vayrynen, *Globalization and Global Governance* (1999)

### 1.1 INTRODUCTION

In today's world of changing health risks and opportunities, the capacity to influence health determinants, status and outcomes cannot be assured through national actions alone because of the intensification of crossborder and transborder flows of people, goods and services, and ideas. The need for more effective collective action by governments, business and civil society to better manage these risks and opportunities is leading us to reassess the rules and institutions that govern health policy and practice at the subnational, national, regional and global levels. This is particularly so as a range of health determinants are increasingly affected by factors outside of the health sector – trade and investment flows, collective violence and conflict, illicit and criminal activity, environmental change and communication technologies. There is an acute need to broaden the public health agenda to take account of these globalizing forces, and to ensure that the protection and promotion of human health is placed higher on other policy agendas (McMichael and Beaglehole 2000). There is a widespread belief that the current system of international health governance (IHG) does not sufficiently meet these needs and, indeed, has a number of limitations and gaps. In light of these perceived shortcomings, the concept of global health governance (GHG) has become a subject of interest and debate in the field of international health.

This paper seeks to contribute to this emerging discussion by reviewing the conceptual meaning and defining features of GHG.<sup>1</sup> This paper begins with a brief discussion of why GHG has become such a subject of discussion and debate. The particular impacts that globalization may be having on individuals and societies, and the fundamental challenges that this poses for promoting and protecting health, are explained. This is followed by a review of the history of IHG and, in particular, the traditional role of the World Health Organization (WHO). The purpose of this brief section is to draw out the distinction between international and global health governance, and the degree to which there is presently, and should be, a shift to the latter.<sup>2</sup> This is achieved by defining, in turn, the terms global health and governance from which the essential elements of GHG can be identified. This leads to an

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<sup>1</sup> A more detailed analysis of the institutional forms and mechanisms of international and global health governance is provided in Fidler D. (2002), "Global Health Governance: Overview of the role of international law in protecting and promoting global public health," Discussion Paper No.3.

<sup>2</sup> A more detailed analysis of the historical dimensions of global health governance is provided in Loughlin K. and Berridge V. (2002), Historical Dimensions of Global Health Governance, Discussion Paper No.2.

identification of key challenges faced by the health community in bringing about such a system in future. The paper concludes with suggestions on how the key types of actors and their respective roles in GHG might be defined further.

## **1.2 HEALTH GOVERNANCE: THE CHALLENGE OF GLOBALIZATION**

In broad terms, **governance** can be defined as the actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals. This a broad term that is encompassing of the many ways in which human beings, as individuals and groups, organize themselves to achieve agreed goals. Such organization requires agreement on a range of matters including membership within the co-operative relationship, obligations and responsibilities of members, the making of decisions, means of communication, resource mobilisation and distribution, dispute settlement, and formal or informal rules and procedures concerning all of these. Defined in this way, governance pertains to highly varied sorts of collective behaviour ranging from local community groups to transnational corporations, from labour unions to the UN Security Council. Governance thus relates to both the public and private sphere of human activity, and sometimes a combination of the two.

Importantly, governance is distinct from *government*. As Rosenau (1990) writes,

*Governance is not synonymous with government. Both refer to purposive behaviour, to goal oriented activities, to systems of rule; but government suggests activities that are backed by formal authority...whereas governance refers to activities backed by shared goals that may or may not derive from legal and formally prescribed responsibilities and that do not necessarily rely on police powers to overcome defiance and attain compliance.*

Government, in other words, is a particular and highly formalised form of governance. Where governance is institutionalised within an agreed set of rules and procedures, regular or irregular meeting of relevant parties, or a permanent organizational structure with appropriate decision making and implementing bodies, we can describe these as the means or mechanisms of governance (Finkelstein 1995), of which government is one form. In other cases, however, governance may rely on informal mechanisms (e.g. custom, common law, cultural norms and values) that are not formalised into explicit rules.

**Health governance** concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population. The rules defining such organization, and its functioning, can again be formal (e.g. Public Health Act, International Health Regulations) or informal (e.g. Hippocratic oath) to prescribe and proscribe behaviour. The governance mechanism, in turn, can be situated at the local/subnational (e.g. district health authority), national (e.g. Ministry of Health), regional (e.g. Pan American Health Organization), international (e.g. World Health Organization) and, as argued in Section 1.5, the global level. Furthermore, health governance can be public (e.g. national health service), private (e.g. International Federation of Pharmaceutical Manufacturers Association), or a combination of the two (e.g. Malaria for Medicines Venture).

Historically, the locus of health governance has been at the national and subnational level as governments of individual countries have assumed primary responsibility for the health of their domestic populations. Their authority and responsibility, in turn, has been delegated/distributed to regional/district/local levels. Where the determinants of health have spilled over national borders to become international (transborder) health issues (e.g. infectious diseases) two or more governments have sought to cooperate together on agreed collective actions. This is discussed in Section 1.3. Growing discussions of the need to strengthen health governance at national, regional, international and, more recently, the global level has, in part, been driven by a concern that a range of globalizing forces (e.g. technological change, increased capital flows, intensifying population mobility) are creating impacts on health that existing forms of governance cannot effectively address. This has led to debates about, for example, the appropriate balance among different levels of governance, what roles public and private actors should play, and what institutional rules and structures are needed to protect and promote human health.

This paper sees **globalization** as an historical process characterised by changes in the nature of human interaction across a range of social spheres including the economic, political, technological, cultural and environmental. These changes are globalizing in the sense that boundaries hitherto separating us from each other are being transformed. These boundaries – spatial, temporal and cognitive – can be described as the dimensions of globalization. Briefly, the spatial dimension concerns changes to how we perceive and experience physical space or geographical territory. The temporal dimension concerns changes to how we perceive and experience time. The cognitive dimension concerns changes to how we think about ourselves and the world around us (Lee 2000b).

Many argue that globalization is reducing the capacity of states to provide for the health of their domestic populations and, by extension, intergovernmental health cooperation is also limited. The impact of globalization upon the capacity of states and other actors to co-operate internationally to protect human health is fourfold. First, globalization has introduced or intensified **transborder health risks** defined as risks to human health that transcend national borders in their origin or impact (Lee 2000a). Such risks may include emerging and reemerging infectious diseases, various noncommunicable diseases (e.g. lung cancer, obesity, hypertension) and environmental degradation (e.g. global climate change). The growth in the geographical scope and speed in which transborder health risks present themselves directly challenge the existing system of IHG that is defined by national borders. The mechanisms of IHG, in other words, may be constrained by its statecentric nature to tackle global health effectively (Zacher 1999b).

Second, as described above, globalization is characterised by a growth in the number, and degree of influence, of nonstate actors in health governance. Many argue that the relative authority and capacity of national governments to protect and promote the health of domestic populations has declined in the face of globalizing forces beyond national borders that affect the basic determinants of health as well as erode national resources for addressing their consequences (Deacon et al. 1997). Nonstate actors, including civil society groups, global social movements, private companies, consultancy firms, think tanks, religious movements and organized crime, in turn, have gained relatively greater power and influence both formally and informally.<sup>3</sup> The

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<sup>3</sup> The emerging and potential role of civil society and private sector in global health governance are discussed in Discussion Paper Nos. 4 and 5.

emerging picture is becoming more complex, with the distinct roles of state and nonstate actors in governance activities such as agenda setting, resource mobilisation and allocation, and dispute settlement becoming less clear. New combinations of both state and nonstate actors are rapidly forming, in a myriad of forms such as partnerships, alliances, coalitions, networks and joint ventures. This apparent “hybridisation” of governance mechanisms around certain health issues is a reflection of the search for more effective ways of cooperation to promote health in the face of new institutions. At the same time, however, it throws up new challenges for creating appropriate and recognised institutional mechanisms for, *inter alia*, ensuring appropriate representation, participation, accountability and transparency.

Third, current forms of globalization appear to be problematic for sustaining, and even worsening existing socioeconomic, political and environmental problems. UNDP (1999), for example, reports that neoliberal forms of globalization have been accompanied by widening inequalities between rich and poor within and across countries. In a special issue of *Development*<sup>4</sup>, authors cite experiences of worsening poverty, marginalisation and health inequity as a consequence of globalization. In some respects, these problems can be seen as “externalities” or “global public bads” (Kaul et al. 1999) that are arising as a result of globalizing processes that are insufficiently managed by effective health governance. As Fidler (1998a) writes, these deeply rooted problems “feed off” the negative consequences of the globalization of health, creating a reciprocal relationship between health and the determinants of health. Although many of these problems are most acute in the developing world, they are of concern to all countries given their transborder nature (i.e. unconfined to national borders).

Fourth, globalization has contributed to a decline in both the political and practical capacity (see reading) of the national governments, acting alone or in cooperation with other states, to deal with global health challenges. While globalization is a set of changes occurring gradually over several centuries, its acceleration and intensification from the late twentieth century has brought attention to the fact that states alone cannot address many of the health challenges arising. Infectious diseases are perhaps the most prominent example of this diminishing capacity, but equally significant are the impacts on noncommunicable diseases (e.g. tobacco-related cancers), food and nutrition, lifestyles and environmental conditions (Lee 2000b). This decapitating of the state has been reinforced by initiatives to further liberalise the global trade of goods and services. The possible health consequences of more open global markets have only begun to be discussed within trade negotiations and remain unaddressed by proposed governance mechanisms for the emerging global economy.

The fourth of the above points is perhaps the most significant because it raises the possibility of the need for a change in the fundamental nature of health governance. As mentioned above, IHG is structured on the belief that governments have primary responsibility for the health of its people and able, in co-operation with other states, to protect its population from health risks. Globalization, however, means that the state may be increasingly undermined in its capacity to fulfil this role alone, that IHG is necessary but insufficient, and that additional or new forms of health governance may be needed. Some scholars and practitioners believe that this new system of health governance needs to be global in scope, so that it can deal effectively with problems caused by the globalization of health (Farmer 1998; Kickbusch 1999).

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<sup>4</sup> *Development*, Special Issue on Responses to Globalization: Rethinking health and equity, December 1999, 42(4).

Globalization, in short, is an important driving force behind the emergence of GHG.

### **1.3 THE ORIGINS OF INTERNATIONAL HEALTH GOVERNANCE**

#### **1.3.1 The growth of health governance in the nineteenth century**

A fuller understanding of the distinction between international and global health governance requires an historical perspective, of which a brief overview is provided here.<sup>5</sup> Historically, we can trace health governance to the most ancient human societies where agreed rules and practices about hygiene and disease were adopted. Early forms of IHG, in the form of cooperation on health matters between two or more countries, span many centuries with the adoption of quarantine practices amidst flourishing trade relations and the creation of regional health organizations. The process of building institutional structures, rules and mechanisms to systematically protect and promote human health across national borders, however, began more concertedly during the nineteenth century. Following the conclusion of the Napoleonic Wars, European states formed a number of international institutions to promote peace, industrial development and address collective concerns including the spread of infectious disease. This process of institutionalisation of IHG, according to Fidler (1997), was a consequence of the intensified globalization of health during this period.<sup>6</sup> Notably, these initiatives enjoyed the support of political and economic elites across European societies who believed that the crossborder spread of disease would hamper industrialisation and the expansion of international trade (Murphy 1995; Fidler 1998a).

The first institution to be created during this period was the International Sanitary Conference, with the first conference held in 1851. The achievements of this meeting, and the ten conferences subsequently held over the next four decades, were limited. In total, four conventions on quarantine and hygiene practices were concluded, along with an agreement to establish an institution for maintaining and reporting epidemiological data, and coordinating responses to outbreaks of infectious diseases (Lee 1998). Importantly, however, the conferences formalised a basic principle that has defined subsequent efforts to build IHG, namely the recognition that acting in cooperation through agreed rules and procedures enable governments to better protect their domestic populations from health risks that cross national borders. As such, the institutions adopted were envisioned as an extension of participating governments' responsibilities in the health field to the international (intergovernmental) level.

Along with this emerging sense of an international health community, constructed of cooperating states, was a growing body of scientific knowledge that was beginning to be shared in a more organized fashion (1998a). Scientific meetings on health-related themes reflected substantial advances during this period in understanding the causes of a number of diseases, such as cholera and tuberculosis. In addition, international meetings were held on social issues that impacted on public health, notably trafficking of liquor and

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<sup>2</sup> A more detailed analysis of the historical dimensions of global health governance is provided in Loughlin K. and Berridge V. (2002), *Historical Dimensions of Global Health Governance*, Discussion Paper No.2.

<sup>6</sup> Early regional health organizations include the Conseil Supérieur de Santé de Constantinople (c. 1830), European Commission for the Danube (1856) and International Sanitary Bureau of the Americas (1902). For a history of health cooperation in the nineteenth century see Howard-Jones N. (1975), *The Scientific Background of the International Sanitary Conferences, 1851-1938* (Geneva: WHO History of International Public Health Series); and Weindling P. ed. (1995), *International Health Organizations and Movements, 1918-1939* (Cambridge: Cambridge University Press).

opium. Between 1851-1913, eighteen international conferences on health were held (Box 1.1), and twelve health-related international institutions<sup>7</sup> had been established by 1914 (Murphy 1995). Among the most prominent were the International Sanitary Bureau (later the Pan American Sanitary Bureau) in 1902 and *Office International d'Hygiene Publique* (OIHP) created in Paris in 1907. The OIHP was a milestone in IHG in that it provided a standing (rather than periodic) forum for countries to exchange ideas and information on public health (Roemer 1994). This was followed in 1920 with the formation of the Health Organization of the League of Nations. While a lack of resources and political support restricted its activities, and inter-organizational competition with the OIHP hindered the scope of its work, the organization emerged from the interwar period with a strong reputation for data collection and public health research.

**BOX 1.1: WORLD AND EUROPEAN CONFERENCES ON HEALTH: 1851-1913**

1851	First Sanitary Conference, Paris
1859	Second Sanitary Conference, Paris
1866	Third Sanitary Conference, Istanbul
1874	Fourth, Sanitary Conference, Vienna
1881	Fifth Sanitary Conference, Washington
1885	Sixth Sanitary Conference, Rome
1887	Liquor on the North Sea, venue unrecorded
1892	Seventh Sanitary Conference, Venice
1893	Eighth Sanitary Conference, Dresden
1894	Ninth Sanitary Conference, Paris
1897	Tenth Sanitary Conference, Venice
1899	Liquor Traffic in Africa, Brussels
1903	Eleventh Sanitary Conference, Paris
1906	Liquor Traffic in Africa, Brussels
1909	Opium, Shanghai
1911	Twelfth Sanitary Conference, Paris
1911	Opium, The Hague
1913	Opium, The Hague

**Source:** Murphy, C.N. (1994), *International Organization and Industrial Change: Global Governance since 1850* (Cambridge: Polity Press), p.59.

From the mid nineteenth century, the nongovernmental sector also began to grow and contribute to IHG, essentially filling gaps or supplementing government action. For example, religious missions and The Rockefeller Foundation's International Health Division (established in 1913) led the way in supporting health services and disease control programmes in many parts of the developing world. The International Committee of the Red Cross (established in 1863) succeeded in establishing the Geneva Convention, a precursor of future international health regimes in setting out norms of behaviour and ethical standards for treating casualties of war. Other notable NGOs created during this period were the League of Red Cross Societies (1919) and Save the Children Fund (1919).

By the 1920s, governmental and nongovernmental health organizations were contributing to a vision of IHG that was increasingly defined by humanitarianism. Many medical practitioners and public health officials building national public health systems at the national level (e.g. Margaret Sanger) became closely involved in designing these early international health institutions. Many of attended international scientific conferences from the mid nineteenth century, bringing with them a strong belief that international

<sup>7</sup> The twelve health-related international institutions established compares with five on human rights, three on humanitarian relief and welfare, and ten on education and research (Murphy 1995).

health cooperation should seek to provide health to as many people as possible. To achieve this vision of 'social medicine' required a strong emphasis on universality as a guiding principal, achieved through the inclusion of as many countries as possible in any international system of health governance that was formed.

### **1.3.2 International Health Governance after the Second World War**

The postwar period brought a significant expansion in IHG through the establishment of new institutions and official development assistance for health purposes. Within the UN system, the World Health Organization (WHO) was created in 1948 as the UN specialised agency for health. Other organizations contributing to health were the UN Relief and Rehabilitation Administration (UNRRA) in 1943, UN International Children's Emergency Fund (UNICEF) in 1946 and UN High Commissioner for Refugees (UNHCR) in 1949. WHO was similar in a number of ways to the Health Organization of the League of Nations that preceded it. Above all, the ideal of universality was, and remains, central to its mandate and activities. As stated by the Constitution of WHO (1946), the overall goal of the organization is "the attainment by all peoples of the highest possible level of health". Even in the face of scepticism at the attainability of such a mandate, and challenges to the appropriateness of social medicine (Goodman 1971), WHO was founded with a strong commitment to addressing the health needs of all people. The universalism of WHO has been reaffirmed on a number of occasions since 1948, most clearly during the 1970s with the Health for All strategy and Renewing Health for All Strategy in the 1990s (Antezana et al. 1998).

WHO's pledge to universality, however, has been strongly defined by the sovereignty of its member states. The working assumption of the organization has been that "health for all" can be achieved by working primarily, if not exclusively, through governmental institutions, notably ministries of health. Universality, in this sense, is measured by number of member states. Where a large number of countries participate, such as the World Health Assembly (WHA), it is assumed that the health needs of all peoples are represented. The role of WHO, in turn, is designed as supporting the efforts of governments to promote and protect the health of their populations.

Beyond national governments NGOs have been allowed to apply for permission to enter into official relations with WHO since 1950 if it is concerned with matters that fall within the competence of the organization and pursues (whose aims and purposes are in conformity with those of the Constitution of WHO). In 1998, there were 188 NGOs in official relations (WHO 1998) from such diverse fields as medicine, science, education, law, humanitarian aid and industry. In principle, therefore, NGOs are recognised as important contributors to achieving the goals of WHO. In practice, however, the actual role NGOs have played has been limited. Lucas et al. (1997), for example, found that WHO has engaged with NGOs in its support at country level in contrast with trends within agencies and other UN organizations such as UNDP and UNICEF. At the headquarters and regional levels, officially recognised NGOs have observed proceedings of the World Health Assembly or meetings of the regional committees, and have limited access to programme-related meetings dealing with more specific health issues. However NGOs have not been routinely consulted despite their importance as channels of health sector aid since the 1980s (Hulme and Edwards 1997) increased.

This traditional focus on member states and, in particular, ministries of health has been in a context of greater diversity of policy actors. By the mid 1990s,

the map of IHG was one of considerable uncertainty, as Zacher (1999bc) describes, fractured into an “organizational patchwork quilt”. Alongside WHO has emerged a multiplicity of players, each accountable to a different constituency and bringing with them different guiding principles, expertise, resources and governance structures. The World Bank maintains a prominent place because of its unrivalled financial resources and policy influence. Regional organizations, such as the European Union, and other UN organizations (e.g. UNICEF, UNDP, UNFPA) retain health as an important component of their work but are more limited in membership and/or scope. The Organization for Economic Cooperation and Development (OECD) and World Trade Organization (WTO) approach health from an economic and trade perspective. Varied civil society groups, such as consumer groups, social movements and research institutions, also make substantial contributions to health development. Finally, the growth of the private sector actors in health, within and across countries, is notable. New fault lines and allegiances had emerged to form an increasingly complex milieu for health cooperation, with interests divided within and across countries and organizations. Undertaking a wide-ranging process of reform, WHO has sought to change some of its traditional governance features, notably its strong focus on ministries of health, by engaging other public and private sector actors, and creating new consultation mechanisms. As discussed in 1.4 below, there have been clear efforts to increase the involvement of the NGO sector in areas of WHO activities, such as tobacco, tuberculosis and HIV/AIDS, since the late 1990s. At the same time, it has reiterated its commitment to universality as the defining principle of its activities. How to define, let alone achieve health for all, remains an enduring challenge.

In summary, IHG has evolved alongside an intensification of human interaction across national borders over a number of centuries, gradually becoming more institutionalised from the mid nineteenth century. During the twentieth century, this institutional framework has grown and spread, encompassing both rich and poor countries, in all regions of the world. The defining feature of IHG has been the primacy given to the state although non-state actors and interests were ever present. By the late twentieth century, however, what Held et al. (1999) calls a “thickening” of the globalization process was challenging this statecentric system of health governance. It is within this context that discussions and debates about global health governance have emerged.

## **1.4 AN EMERGING SYSTEM OF GLOBAL HEALTH GOVERNANCE?**

The precise origins of the term GHG are unclear, although many scholars and practitioners who use the term draw upon a number of different fields. These mixed origins mean that GHG can be difficult to define. This problem of definition is compounded by the fact that the term GHG is used widely in a number of different contexts. We can begin to overcome this problem of definition by breaking GHG into its component parts – global health and governance.

### **1.4.1 International versus global health**

Globalization brings into question how we define the determinants of health and how they can be addressed. In principle, the mandate of WHO is based on a broad understanding of health<sup>8</sup>, although in practice its activities have

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<sup>8</sup> The Constitution of WHO defines health as “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.”

traditionally been biomedical in focus. Since the 1970s, efforts have been made to incorporate a more multisectoral and multidisciplinary approach into the organization's activities. For example, *Health for all in the 21<sup>st</sup> Century* links the attainment of good health to human rights, equity, gender, sustainable development, education, agriculture, trade, energy, water and sanitation (Antezana et al. 1998). Similarly, the replacement of the Global Programme on AIDS by UNAIDS was in large part due to a desire to go beyond a narrow biomedical approaches to HIV/AIDS (Altman 1999).

Globalization from the late twentieth century has emphasised even more poignantly the need for greater attention to the basic determinants of health including so-called non-health issue areas. In arguing for a reinvigoration of public health, McMichael and Beaglehole (1999) point to the need to address underlying socioeconomic (notably inequalities), demographic and environmental changes that global change is creating. Similarly, Chen et al. (1999) argue that globalization is eroding the boundary between the determinants of public (collective) and private (individual) health. For example, susceptibility to tobacco-related diseases, once strongly linked to, and blamed on, the lifestyle choices of individuals, is increasingly seen as attributable to the worldwide marketing practices of tobacco companies. The distinction between *global* health and *international* health therefore is that the former entails a broadening of our understanding of, and policy responses to, the basic determinants of health to include forces that transcend the territorial boundaries of states. Global health requires a rethinking of how we prioritise and address the basic determinants of health, and engagement with the broad range of sectors that shape those underlying determinants.

The need to address the basic determinants of health leads to the practical question of how to do so. Since at least the early 1990s, there has been a growing confusion of mandates among UN organizations that have substantial involvement in the health sector - WHO, UNICEF, UNDP, UNFPA and the World Bank. In large part, this has been due to efforts to develop multisectoral approaches to both health and development, as well as key areas (e.g. reproductive health, environmental health) that bring together the activities of two or more organizations (Lee et al. 1996). Globalization invites a further widening of the net of relevant organizations, requiring engagement with actors that have little or no formal mandate in the health field. Notable have been efforts to establish greater dialogue between WHO and the WTO. While trade interests have historically defined, and in many ways confined, international health cooperation, officially the two spheres have been addressed by separate institutions. Nonetheless, the multiple links between trade and health policy are well recognised (WHO 2002, Brundtland 1998; Brundtland 1999), resulting in high-level meetings between the two organizations since the late 1990s. At present, WHO holds official observer status on the Council of the WTO, and committees relating to Sanitary and Phytosanitary Measures (SPS) and Technical Barriers to Trade (TBT) agreements. However, the capacity to articulate public health concerns regarding, for example, the agreement on trade-related intellectual property rights (TRIPS), has been hampered by the framing of health among trade officials as a "non-trade issue", and as such the reluctance of certain countries to discuss health within the context of a trade negotiations. Moreover, the ability of WHO to influence the WTO has been hampered by the fact that states (many of which are members of both organizations) have accorded a higher priority to trade issues, rather than those relating to human health. As such, there remain considerable barriers to incorporating health as a legitimate and worthy concern on the global trade agenda.

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## 1.4.2 The different meanings of governance

As described above, the ability of a society to promote collective action and deliver solutions to agreed goals is a central aspect of governance. As shown in Table 1.1 the term governance has been used in a number of different ways, ranging from the relatively narrow scope of corporate and clinical governance, to the broader concept of global governance.

**TABLE 1.1: VARIOUS USES OF THE TERM GOVERNANCE**

TYPE OF GOVERNANCE	CHARACTERISTICS
governance	<ul style="list-style-type: none"> <li>• the actions and means to promote collective action and deliver collective solutions</li> <li>• "an exercise in assessing the efficacy of alternative modes (means) of organization. The object is to effect good order through the mechanisms of governance" (Williamson 1996: 11)</li> <li>• "The manner in which power is exercised in the management of a country's economic and social resources for development" (World Bank 1994)</li> </ul>
corporate governance	<ul style="list-style-type: none"> <li>• clear systems of transparency and accountability to investors</li> <li>• mechanisms for meeting social responsibility by corporations</li> <li>• "the framework of laws, regulatory institutions, and reporting requirements that condition the way that the corporate sector is governed" (World Bank 1994)</li> </ul>
good governance (World Bank 1994)	<ul style="list-style-type: none"> <li>• public sector management</li> <li>• accountability of public sector institutions</li> <li>• legal framework for development</li> <li>• transparency and information</li> </ul>
good governance (UNDP 1997)	<ul style="list-style-type: none"> <li>• management of nations affairs</li> <li>• efficiency, effectiveness and economy</li> <li>• liberal democracy</li> <li>• greater use of non-governmental sector</li> </ul>
clinical governance	<ul style="list-style-type: none"> <li>• "a framework through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (UK 1998)</li> </ul>
global governance	<ul style="list-style-type: none"> <li>• "not only the formal institutions and organizations through which the rules and norms governing world order are (or are not) made and sustained - the institutions of the state, inter-governmental co-operation and so on - but also those organizations and pressure groups - from MNCs, transnational social movements to the plethora of non-governmental organizations - which pursue goals and objectives which have a bearing on transnational rule and authority systems" (Held et al. 1999)</li> </ul>

Recent interest in governance within the development community can be traced to the late 1980s as part of a desire among aid agencies to address the uneven performance of low and middle-income countries to macro economic reforms (Dia 1993). The term **good governance** was introduced by the World Bank (1994) as an explanation for problems being experienced in many countries, namely the weakness of public sector institutions and management, and as a basis for setting further lending conditionalities. In this context, governance is defined as "the manner in which power is exercised in the management of a country's economic and social resources of development."

For governance to be "good", social and economic resources must be managed by a small efficient state that is representative, accountable, transparent, respectful of the rule of law, and supportive of human rights through programmes of poverty reduction.

The conceptualisation and application of the term good governance by the World Bank is seen by Leftwich (1993) as problematic in a number of ways. First, he argues that it is an extension of neoliberal-based policies, (for example, structural adjustment programmes) that are arguably themselves contributing to the problems experienced by many countries since the 1980s. Second, the World Bank focuses narrowly on the performance of public sector administration and management, while ignoring the importance of good governance for the private sector or donor community itself, along with levels of foreign debt, in influencing how countries have fared. Third, the prescriptive element of good governance again focuses on governments, while at the same time adopting a technocratic view of how governments should work.

Other development agencies have since taken up the term good governance as important components of their policies<sup>9</sup>. The UN Development Programme (UNDP) is a notable example. In seeking to go beyond public sector management, UNDP (1997) has incorporated a range of principles into its conceptualisation of good governance including legitimacy (democracy), freedom of association, participation, and freedom of the media. As Deputy Director of the UN Department for Development Support and Management Services A.T.R. Rahman (1996) states, "good governance is an overall process that is essential to economic growth, to sustainable development and to fulfilling UN-identified objectives such as the advancement of women and elimination of poverty".<sup>10</sup>

Another increasingly used term is **corporate governance**. Williamson (1996) defines corporate governance, for example, in terms of recent developments on transaction-cost approaches in economic theory. He writes that governance concerns institutional structures and accompanying practices (e.g. rules) that facilitate economic production and exchange relations. "Good" governance structures are those that effectively "mitigate hazards and facilitate adaptation". These can be simple or complex depending on the degree of hazard faced. Other writers on corporate governance similarly focus on mechanisms that enhance economic transactions. The underlying assumption of such approaches is that good corporate governance, in the form of improved (more democratic) systems of accountability and transparency for investors, will enhance the process of wealth creation and prevent greater regulation by governments (McRitchie 1998).

A broader perspective on corporate governance is more closely related to the definition of good governance put forth within the development community. This approach focuses more directly on the nature of social responsibility by business, rather than the enhancement of profits. There has been a growing movement to encourage the corporate sector to be more responsible, not only to shareholders, but to the wider communities within which they operate. The notion of corporate responsibility and citizenship has thus arisen in relation to such practices as fair trade, ethical investment and activist shareholders,

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<sup>9</sup> For the UK government's view on good governance see Department for International Development (DfID), *Eliminating World Poverty: A Challenge for the 21<sup>st</sup> Century* (DfID, 1997). See also UN General Assembly, Resolution 50/225, 1996.

<sup>10</sup> Since completion of this paper, the UNDP Poverty Report 2000, has expanded on the link between "good governance" and poverty relief.

social and environmental impact assessments, improved working conditions for workers in low-income countries, and the social auditing of companies (Cantarella 1996).

The values of management-oriented approaches to corporate governance have entered the health lexicon in the guise of **clinical governance**. In the UK, where the term that has become especially popular, clinical governance refers to “a framework through which NHS [National Health Service] organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.” (UK 1998). Initially emerging as part of health sector reform, it has been a response in particular to differences in quality of care in parts of the country, and to public concerns regarding well-publicised cases of poor clinical performance. The focus, therefore, has been improving the quality of patient care through evidence based practice, collecting information to measure performance against agreed standards, providing ongoing education for health care professionals, and managing and learning from complaints (Scally and Donaldson 1998). Institutional mechanisms (e.g. National Institute for Clinical Excellence) and practices have been introduced for these purposes (Paris and McKeown 1999; The King's Fund 1999). Criticisms of clinical governance focus on whether there is anything new about its aims. Some argue that clinical governance offers little more than a confirmation of “the common sense message that we [doctors and health professionals] must all strive after quality in practising medicine” (Goodman 1998).

A further use of the term governance, and the focus of this paper, is **global governance** which can be broadly defined as

*not only the formal institutions and organizations through which the rules and norms governing world order are (or are not) made and sustained – the institutions of the state, inter-governmental co-operation and so on – but also those organizations and pressure groups – from MNCs, transnational social movements to the plethora of non-governmental organizations – which pursue goals and objectives which have a bearing on transnational rule and authority systems.*

(Held et al. 1999).

The concept of global governance has come to the health field from the discipline of International Relations (IR) within which a diverse, and theoretically riven, debate has developed on the specific nature of globalization, the emerging global order, key actors, and ultimate goals of global governance (Table 1.2). **Liberal-internationalist** scholars view the purpose of global governance as ultimately moving towards a more liberal democratic global order in which states and IGOs have equal roles. Within such an order it is envisaged that power and influence will flow in a top-down manner, although states and IGOs may be held accountable via a global assembly composed of representatives from national and global civil society (Commission on Global Governance 1995). In contrast, **radical/critical** scholars believe that the direction of global governance should be guided from the bottom-up. Emphasis is placed on the potential of actors from within (global) civil society (in particular social movements) to bring about more ‘humane governance’ (Gill 1998). **Cosmopolitan democrats** pursue a vision of global governance that embraces the diversity of people across national and other forms of identity within a shared political community. This ideal may be achieved, for instance, through consensus on universal principles (e.g. human rights), increased public scrutiny of existing IGOs, global referendums and an

expanded international legal system (Held 1995; McGrew 1997). This is a somewhat simplistic summary of a substantial and intellectually rich literature.<sup>11</sup>

**TABLE 1.2: THEORETICAL APPROACHES TO GLOBAL GOVERNANCE**

<b>CENTRAL ISSUE OF GLOBAL GOVERNANCE</b>	<b>LIBERAL-INTER NATIONALISM</b>	<b>CRITICAL/RADICAL</b>	<b>COSMOPOLITAN DEMOCRACY</b>
<i>Globalization</i>	Multi-causal process – generates interdependence and 'zones of peace'	Economically driven – subject to contradictions	Multi-causal process with transformative potential
<i>Nature of the current global order</i>	Emerging post-Westphalian order	Global neoliberalism	Post-Westphalian order
<i>Actors in global governance</i>	States, international organizations corporations and NGOs etc.	Transnational capitalist class, elites through states, International organization and civil society.	States, peoples, international organization, corporations and social movements
<i>Key actors in collective problem solving</i>	States and international organization	Transnational capitalist class, international organization, states and civil society.	States, international organization, corporations and social movements
<i>Nature of global governance</i>	Reformist and top-down	Revolutionary and bottom-up	Transformationalist and participatory
<i>Change towards</i>	Liberal democratic consensus politics	Humane governance	Cosmopolitan democracy

Source: Adapted from McGrew A. (1997), "Globalization and Territorial Democracy: an introduction" in McGrew A. ed., *The Transformation of Democracy?* (London: Polity Press), p.20.

To summarise, the concept of governance has generally been used in two broad ways in relation to health. The first defines governance as a problem-solving approach to address the shortfalls of public and private institutions to function efficiently. Strongly influenced by recent developments in management and economic theory, good or better governance is equated with strengthening efficiency and effectiveness within existing institutional structures. The second takes a more transformative approach by finding existing forms of governance falling short in its responsiveness to the needs of society as a whole. Faced with a range of intensifying and/or new risks and opportunities, more effective governance is believed to be needed to respond to social change. This volume is located within this second view in its efforts to encourage wider discussion of the challenges posed by globalization, and the clearer vision needed to address them through global governance.

### **1.4.3 The essential elements of global health governance**

From the above discussion, we can identify some essential elements of GHG and the challenges for achieving them. The first is the "deterritorialisation" of how we think about and promote health, and thus *the need to address factors which cross, and even ignore, the geographical boundaries of the state*. The formation of the international system of states in the sixteenth century, the birth of public health during the nineteenth century, and the creation of national health systems in the twentieth century have contributed to a system of governance that is premised on protecting the integrity of the state. IHG has been historically focused on those health issues that cross national borders, with the aim of protecting domestic populations within certain defined geographical boundaries through such practices as quarantine, cordon

<sup>11</sup> For a more detailed discussion see Hewson and Sinclair (1999).

sanitaire, and internationally agreed standards governing the reporting of infectious disease, trade and population mobility. All of these efforts have been focused on the point of contact, the national border of states.

However, forces of global change, in various forms, have intensified crossborder activity to such an extent as to undermine the capacity of states to control them. The increased levels of international trade and movement of people are examples. Moreover, a wide range of others forces render national borders irrelevant. The worldwide flows of information and communication across the Internet; the ecological impacts of global environmental change; the frenzied exchange of capital and finance via electronic media; the illicit trade in drugs, food products and even people; and the global mobility of other life forms (e.g. microbes) through natural (e.g. bird migration) and manmade (e.g. bulk shipping) means render border controls irrelevant. Many of these global changes impact on health and requires forms of cooperation that go beyond IHG.

A second essential element of GHG is *the need to define and address the determinants of health from a multi-sectoral perspective*. Biomedical approaches to health have dominated historically in the form of disease-focused research and policy, the skills mix of international health experts and officials, and the primacy given to working through ministries of health and health professionals. A global system of health governance begins with the recognition that a broad range of determinants impact on population health including social and natural environments. In recent decades, this has been recognised to some extent through the increased involvement of other forms of expertise in health policy making (e.g. economics, anthropology) and links with other social sectors (e.g. education, labour). More recently, ministries of health and international health organizations have sought to engage more directly with sectors traditionally seen as relatively separate from health (e.g. trade, environment, agriculture) in recognition of “cross sectoral” policy issues at play. Informal consultations between WHO and WTO, for example, have been prompted by the importance of multilateral trade agreements to health.

The main challenge to achieving greater cross sectoral collaboration lies in the danger of casting the health “net” so widely that everything becomes subsumed within the global health umbrella. Opening up GHG too indiscriminately can dilute policy focus and impact, and raise questions about feasibility. The linking of traditional health and non-health issues also demands a clear degree of understanding and empirical evidence about cause and effect. Defining the scope of GHG, therefore, remains a balance between recognising the interconnectedness of health with a varied range of globalizing forces, and the need to define clear boundaries of knowledge and action.

The third essential element of GHG is *the need to involve, both formally and informally, a broader range of actors and interests*. As described above, while nonstate actors have long been an important part of the scene, IHG has been firmly state-defined. Health-related regional organizations (e.g. PAHO, European Union), along with major international health organizations such as WHO and the World Bank are formally governed by member states. Their mandates, in turn, are defined by their role in supporting the national health systems of those member states. The universality of their activities is measured by the number of member states participating in them. Defining criteria and measures of progress to address the burden of disease, health determinants and health status are focused on the state or groups of states.

GHG, however, is distinguished by the starting point that globalization is creating health needs and interests that increasingly cut across and, in some

cases, are oblivious to state boundaries. To effectively address these global health challenges, there is a need to strengthen, supplement and even replace existing forms of IHG. Importantly, this does not mean that the role of the state or IHG will disappear or become redundant, but that they will rather need to become part of a wider system of GHG. Many existing institutions will be expected to play a significant role in GHG, and states will continue to be key actors. However, states and state-defined governance alone is not enough. Forms of governance that bring together more concertedly state and nonstate actors will be central in a global era (Scholte 2000). As described by the Commission on Global Governance (1995), “[global governance] must...be understood as also involving NGOs, citizen’s movements, multinational corporations, and the global capital market,” as well as a “global mass media of dramatically enlarged influence.”

As described above, state and nonstate actors have long interacted on health governance. The difference for GHG will lie in their degree of involvement and nature of their respective roles, varying with the health issue concerned. Three brief examples illustrate this. First, relations among the diverse NGO community are constantly changing depending on the issue. On certain issues, they may be willing to form strategic networks or alliances with other NGOs, thus representing an important governance mechanism within GHG. Such a mechanism was formed around the global campaign against the marketing of breastmilk substitutes that led to the formation of the International Baby Food Action Network. Cooperation among the International Baby Food Action Network, UNICEF, WHO and selected governments led to the International Code of Marketing on Breast-Milk Substitutes in 1981. Like-minded NGOs also came together to form more permanent, but still highly fluid, global social movements around the environment and women’s health. These movements opposed each other at the UN Conference on the Environment and Development (1992), yet worked together to propose an alternative view of development at the World Summit for Social Development in 1995. Close relations among the women’s health movement, national governments and UNFPA was also a defining feature of the International Conference on Population and Development (1994). Relations between the women’s health movement and some states, in particular the US, were so close that members of the women’s health movement served on some of the official government delegations. Parties involved in the conference believed that such close relations played a key role in shaping the resultant commitment to reproductive health (Dodgson 1998).

A second example is the closer relations among state and nonstate actors characterising the emerging global strategy on tobacco control. Under the auspices of WHO, negotiations for a Framework Convention on Tobacco Control (FCTC) have been attended by officially recognised NGOs, along with state delegations. The Tobacco Free Initiative (TFI), WHO maintains that NGO participation is central to the overall success of the FCTC, and has supported the creation of a global NGO network to support the FCTC (i.e. Framework Convention Alliance). Links were also formed with representatives of the women’s movement to ensure that tobacco and women’s health was discussed during the Beijing Plus 5 process. At the same time, TFI has developed links with the business community, in particular, the pharmaceutical industry, to explore how nicotine replacement treatments can be made more widely available. Other coordination efforts have been focused on bringing together different UN organizations through the formation of a UN Ad Hoc Inter-Agency Task Force on tobacco control, and the holding of public hearings to

encourage the submission of a wide range of evidence from different interest groups.<sup>12</sup>

These efforts to build formal links with such a diverse range of stakeholders to support global tobacco control policy is unprecedented for WHO, and a good example of emerging forms of GHG. It represents an important challenge to traditional ways of working for WHO in its efforts to tackle health issues with global dimensions (Collin et al. 2002). Ensuring state and nonstate actors work collectively on different levels of governance (i.e. global, regional, national<sup>13</sup> and subnational), the FCTC is an example of how “behind-the-border” convergence could be promoted in the future. The goal of adopting a legally binding treaty and associated protocols is also a new development in institutionalising global governance in the health sector. The FCTC is based on international regimes that have emerged to promote collective action on global environmental problems. These international regimes can be defined as “sets of implicit or explicit principles, norms, rules and decision-making procedures around which actors expectations converge in a given area of international relations” (Krasner 1983). In addition to the FCTC, other examples of international regimes in the field of health are the International Health Regulations<sup>14</sup>, the International Code for the Marketing of Breast Milk Substitutes and the Codex Alimentarius (Kickbusch 1999). These examples of international health regimes demonstrate that they have played a significant role in IHG. The remit and organizational structure of the FCTC and its implementation suggest that such regimes will be a core feature of GHG in future.

A third example of state-nonstate governance is so-called global public-private partnerships (GPPPs) defined as “a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and inter-governmental organizations, so as to achieve a shared health creating goal on the basis of a mutually agreed division of labour” (Buse and Walt 2001). Among the most prominent GPPPs are the Albendazole Donation Programme, Medicines for Malaria Venture and International AIDS Vaccine Initiative. The idea of building partnerships with business is at the centre of UN-wide views on the governance of globalization (Global Compact). For this reason, and the fact that GPPPs bring much needed resources to major health issues, the number of GPPPs is likely to grow in future. At the same time, like the FCTC process, GPPPs require a period of reflection on a range of governance issues. Buse and Walt (2001), for example, raise questions about accountability, transparency and long-term sustainability of GPPPs. They also ask who benefits, people who seek treatment or the pharmaceutical companies that gain good public relations. Some governments of low-income countries, a number of NGOs and UN institutions have expressed concerns about the viability of building links among actors with fundamentally differing objectives and interests. For example, Carole Bellamy, UNICEF Executive Director comments, “it is dangerous to assume that the goals of the private sector are

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<sup>12</sup> Interview with Douglas Bettcher, Framework Convention Team, Tobacco Free Initiative, Geneva, 9 December 1999.

<sup>13</sup> Technical documents that have been written as part of the consultation process for the FCTC suggest that all signatory states should adopt an autonomous national tobacco control commission. See for example, A. Halvorsen, “The Role of National Institutions in Developing and Implementing the WHO Framework Convention on Tobacco Control”, *Framework Convention on Tobacco Control: Technical Briefing Series*, No.5 (1999).

<sup>14</sup> Following a long process of review, the International Health Regulations (IHRs) are on the brink of being reformed to make them more effective and binding on states. Most significantly, the revised IHRs require the reporting of all “events of urgent international importance related to public health”.

somehow synonymous with those of the United Nations, because they most emphatically are not.”<sup>15</sup>

Thus, global health emphasises the need for governance that incorporates participation by a broadly defined “global” constituency, and engaging them in collective action through agreed institutions and rules. The challenges of achieving GHG, defined in this way, are considerable. At the heart lies the need to define the core concept of democracy in the context of globalization in terms of political identity and representation. If existing forms of health governance are seen to be undemocratic, alternatives that appropriately balance actors and interests are needed. Systems for ensuring accountability and transparency must be agreed. There requires greater clarity about what contributions different actors make to GHG, and what governance mechanisms can ensure that these roles are fulfilled. The issue of meaningful participation and responsibility remains problematic. For example, the WHA is attended by WHO member states but there are inequities in capacity to follow proceedings and contribute to decision making. This is a challenge for many international organizations including the WTO. Conflicts are also likely to emerge and need to be resolved. The familiar yet enduring problem of coordination of international health cooperation remains unresolved. Overall, the principle of closer state-nonstate cooperation is an increasingly accepted one, but the “hitty gritty” of what this should look like in practice is only beginning to be explored within the health sector. This theme is taken up by discussion papers on the potential role of civil society and the private sector in this series.

## **1.5 CONCLUSIONS: BEGINNING TO DEFINE AND SHAPE THE ARCHITECTURE FOR GHG**

The task of defining and shaping a system of GHG in further detail, both as it appears to be currently evolving and more prospectively, begins with a number of important challenges for research and policy. The first, and perhaps the most fundamental, is the need to agree the normative framework upon which GHG can be built. There is a need to reach some degree of consensus about the underlying moral and ethical principles that define global health cooperation. As discussed in this paper, universalism has been a strong ethos guiding the emergence of social medicine, the Health for All movement from the late 1970s and, more recently, calls for health as a human right. Alongside such communitarian ideas have been approaches informed by principles of entitlement (economic or otherwise) and utilitarianism. Despite recent high-profile initiatives on “global health”, an informed discussion about their normative basis remains to be carried out.

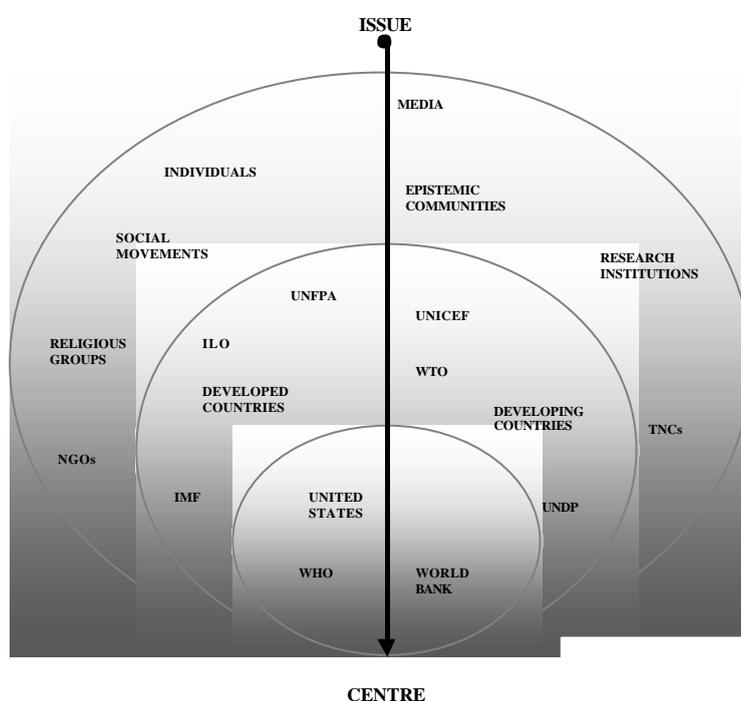
A second challenge is the need to define leadership and authority in GHG. As discussed above, health cooperation has evolved into an arena populated by a complex array of actors operating at different levels of policy and constituencies, with varying mandates, resources and authority. Figure 1 is an attempt to identify the key actors potentially concerned with GHG and their possible positions at a given point in time. WHO and the World Bank are shown as central because they represent the main sources of health expertise and development financing respectively. At the same time, they are accompanied by a cluster of institutions, state and nonstate, that fan outwards including, but are not restricted to, the International Monetary Fund (IMF), World Trade Organization (WTO), United Nations Children’s Fund

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<sup>15</sup> Interview with J. Ann Zammit, The South Centre, 9<sup>th</sup> December 1999. “UNICEF: Bellamy warns against partnership with private sector”, *UN Wire*, 23<sup>rd</sup> April (1999).

(UNICEF), International Labour Organization (ILO), United Nations Development Programme (UNDP), and United Nations Population Fund (UNFPA). Specific regional and bilateral institutions (e.g. USAID) are included as politically and economically influential.<sup>16</sup> GHG also includes the wide variety of actors within the private sector and civil society, the latter defined as “a sphere of social interaction between economy and state, composed above all of the intimate sphere (especially family), the sphere of associations (especially voluntary associations) and forms of public communication” (Jareg and Kaseje 1998). Some of these actors (e.g. Bill and Melinda Gates Foundation) have become highly prominent in recent years. Others, as described above, including NGOs, social movements, epistemic communities, professional associations and the mass media, can be influential on a more policy specific basis.

**FIGURE 1: GLOBAL HEALTH GOVERNANCE MAPPED**



In this complex arena of actors, the issue of leadership and authority is a difficult one. As well as setting the normative framework for global health cooperation, leadership can provide the basis for generating public awareness, mobilising resources, using resources rationally through coordinated action, setting priorities, and bestowing or withdrawing legitimacy from groups and causes. The willingness of states to ‘pool’ their sovereignty and act collectively through mechanisms of GHG is one historically significant hurdle. The absence of a single institution, with the authority and capacity to act decisively, to address health issues of global concern is another. The panoply of vested interests that characterise global politics represents another clear difficulty. After the Second World War, the agreement to establish the World Health Organization was prompted by a strong collective recognition of the need to improve health worldwide. The global nature of many emerging health issues, including the threat of major threats to humankind (e.g. emerging diseases, antimicrobial resistance) may prompt similar consensus.

<sup>16</sup> This is not to suggest of course that these are the only bilateral actors to play a role in international health, United Kingdom’s Department for International Development is one many other such institutions.

A third challenge for GHG is the need to generate sufficient resources for global health cooperation and distribute them appropriately according to agreed priorities. The present system is ad hoc in nature, reliant on the annual spending decisions of governments, and the goodwill of private citizens and companies. Efforts to provide debt relief and increase development assistance recognise the inherent inequities of current forms of globalization (UNDP 1999). Recent discussions about the creation of a Tobin Tax or equivalent surcharge, on global activities that rely on a secure and stable world (e.g. financial transactions, air travel), could generate substantial and much needed sums.

Fourth, the sovereignty of states is also a hurdle to giving “teeth” to global health initiatives because of the lack of effective enforcement mechanisms. With the exception of the International Health Regulations, which in itself is highly circumscribed in remit, WHO can recommend rather than command action by member states. The reporting of outbreaks of yellow fever, cholera and plague, for example, is traditionally reliant on governments who may not be willing to report such information for fear of causing adverse economic reactions. By definition, a global health issue is one where the actions of a party in one part of the world can have widespread consequences in other parts of the world. Reliance on voluntary compliance with agreed practices, such as the use of antibiotics and antimicrobials, without sufficient monitoring and enforcement, can lead to serious and even irreversible health impacts.

Finally, the enigma of how to achieve a more pluralist, yet cohesive, system of GHG stands before us. As the globalization of health continues, health governance will have to become broader in participation and scope. The proto forms of GHG that are presently emerging (e.g. FCTC, GPPPs) might be seen as examples of improving practice as they open up participation in health governance to a wider range of actors. Nonetheless, a critical evaluation of these forms of governance is yet to be undertaken, nor is it yet clear whether these emerging forms of GHG will achieve their objectives.

The task of moving forward this complex, yet much needed, debate can be facilitated by a number of further tasks that are the focus of future discussion papers in this series. The purpose of this paper has been to review the conceptual meaning of GHG and, in turn, to highlight the challenges faced in moving towards such a system. A second task is to better understand the historical context of IHG and GHG, and how this can inform the transition from one to the other. Many different types of governance mechanisms for health purposes have been tried and tested since the end of the Second World War, and it would be useful to explore these in relation to the criteria set in this paper. This is the subject of Discussion Paper No. 2.

The next task is to better understand the “nitty gritty” of global governance in terms of what, in concrete terms, it looks like in practice. This moves us into the legal realm where international lawyers have grappled with the formulation and implementation of governance at the global level. An examination of what currently exists within the health field, as well as other fields such as trade and environment, may shed light on future possibilities. While such a review can only be selective in nature, it can point to lessons for building mechanisms for GHG. This is the subject of Discussion Paper No. 3.

Lastly, there is the task of defining more clearly the potential role of nonstate actors within a system of GHG. Relationships, patterns of influence and agreed roles among state and nonstate actors within an emerging system of GHG are still emerging. This myriad of different actors, each with individual

spheres of activity, types of expertise, resources, interests and aspirations, cannot yet be described as a "global society". As defined by Fidler (1998b), a global society is "made of individuals and non-state entities all over the world that conceive of themselves as part of a single community and work nationally and transnationally to advance their common interests and values." The ad hoc nature of GHG so far, however, suggests that a more concerted effort to define and describe existing and potential roles would contribute to policy debates on possible future directions. The potential role of civil society in GHG is the subject of Discussion Paper No. 4, and the potential role of the private sector is examined in Discussion Paper No. 5.

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