

Are Existing Governance Structures Equipped to Deal with Today's Global Health Challenges - Towards Systematic Coherence in Scaling Up

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The global financial crisis and a new political era shaped by the new US administration have led to a revival of interest in effective global health governance, and provide an opportunity to review existing mechanisms in the context of contemporary global health challenges. On the underlying premise that “global governance is actually global problem solving” it is proposed that the primary objective of good global health governance is to strengthen healthcare delivery systems in the developing world with an emphasis on the importance of primary health care. In order to achieve this objective, innovations which take into account new global political and economic realities are needed. A multi-level, multi-party and multi-purpose partnership framework of global health governance (global, regional, national) is put forward which includes all the key players and attempts to integrate the key functions needed to achieve an inclusive, equitable, flexible, democratic and sustainable mechanism. Based on shared values of solidarity, democracy and equity, and fully acknowledging the sovereignty of countries and other stakeholders, the proposed framework consists of a multilateral governance platform coordinated by the World Health Organization supported by high-level political commitment and policy coherence, and ultimately operationalised by effective implementation mechanisms through global action networks (GANs). GANs are a mode of governance involving authoritative negotiations between state and non-state players which have interests and capacities to influence and shape outcomes in specific issue areas.

INTRODUCTION: THE CHALLENGE OF GLOBAL HEALTH

In order to improve health and health equity, especially in the developing world, effective, equitable and sustainable mechanisms of global health governance (GHG)¹ are needed to deal with the complex and diverse challenges facing health today. On the underlying premise that “global governance is actually global problem solving” it is proposed that the primary objective of good global health governance is to strengthen healthcare delivery systems in the developing world with an emphasis on the importance of primary health care. In recent times, the GHG field has been driven by the influences of globalization², and health policy has had to take into account a range of global issues including pandemic disease, human migration, conflict, urbanization, travel, global trade, health care financing, information and communications technology, role of civil society, health law, health diplomacy and climate change. The risks to health and development caused by globalization disproportionately affect populations living

in the developing world, as exemplified by the potential health impacts of climate change and global warming.³

Most recently, there are fears that the current global financial crisis will have a negative impact on global health through, for example, cuts in the health budgets of resource-limited countries as well as reduced aid flows from OECD countries.⁴ Health, as well as education, are often the first victims of budget cuts in times of limited funding and competing priorities, and the crisis is likely to place increased pressure on publicly-funded healthcare delivery systems. As the crisis originated in the now debt-ridden developed world, overseas development aid in health may be similarly affected and will, in particular, impact on countries where external resources make up a significant proportion of national health budgets. Although global health aid accounts for only 0.3 percent of total expenditures on health globally (6.5 percent in sub-Saharan Africa), in some countries like the Solomon Islands and Mozambique, for example, 82 percent and 66 percent of the national health budgets respectively come from external sources.⁵ WHO estimates that 23 countries have over 30 percent of their total health expenditures funded by donors.

In terms of disease challenges, threats of epidemics and pandemics continue as demonstrated by recent outbreaks of cholera in Zimbabwe, Ebola virus in Angola and increased activity associated with avian influenza. The threat of an entirely new pathogen emerging was illustrated with the appearance of a new influenza A (H1N1) virus in 2009 and the detection of a new arenavirus in 2008 which caused a fulminant haemorrhagic fever, killing 4 out of 5 people it infected⁶ – amid other concerns that a strain of Ebola virus may have moved from pigs to humans.⁷ Murray *et al* have estimated that an influenza pandemic occurring today may kill 51-81 million people with 96 percent of the deaths occurring in the developing world.⁸ Developing countries also have to deal with the additional burden of chronic diseases and injuries, estimated to make up 70 percent of the global disease burden by 2020.⁹

It is against this background of contemporary global health challenges that we examine whether the current mechanisms and structures in GHG are equipped to deal with the global health challenges facing us today. We start by describing what the current global health landscape looks like.

GLOBAL HEALTH LANDSCAPE

The essential functions of GHG are generally agreed upon and include convening, defining shared values, ensuring coherence, establishing standards and regulatory frameworks, providing direction (e.g. setting priorities), mobilizing and aligning resources, and promoting research.¹⁰ Dodgson *et al* have reviewed the conceptual meaning and defining features of global health governance (GHG), emphasizing that globalization is an important force behind the emergence of the GHG concept.¹¹ They consider that GHG has several essential

elements including its trans-national and cross-border nature, its need to see health determinants from a multi-sectoral perspective and the desirability to be inclusive of all key actors and stakeholders. They have attempted to identify and map the key actors and their possible positions at a given time in the GHG framework. This mapping places international organizations (e.g. WHO, World Bank) at the centre but complemented by a cluster of state and non-state players “fanning” outwards and dealing with specific health issues.

By Dodgson *et al*¹² and others¹³, the main institutions have been identified as ranging from multilateral organizations (e.g. WHO, UNAIDS, UNFPA, UNICEF, World Bank), multi-country networks (e.g. G8, G20, G24), regional entities (EC/EU, ASEAN), partnerships (e.g. Global Fund, GAVI, International Health Partnership+, UNITAID, MMV, GABTD, IAVI), bilateral (e.g. UK DFID, Germany’s GTZ, USAID, PEPFAR) initiatives and agencies, philanthropies (e.g. the Bill & Melinda Gates Foundation, Carso Foundation) and the private sector (e.g. Unilever) and civil society (e.g. People’s Health Movement, Oxfam, MSF).

A general trend over the past two decades involving a number of these institutions has been an unprecedented increase in the number and available resources for global health initiatives aimed at improving health in the developing world. It is estimated that there are more than 40 bilateral donors, 26 UN agencies, 20 global and regional funds, and 90 global health initiatives active at the moment.¹⁴ These initiatives have been accompanied by significant resources. Prah Ruger has estimated that global financial investments in health doubled from US\$6 billion in 2000 to nearly US\$14 billion in 2005¹⁵, and this figure may reach US\$20 billion in 2008. With the caveat that some overlaps exist between various initiatives, another analysis suggests that more than US\$40 billion have been pledged, committed or spent by 9 initiatives launched between 1998-2005.¹⁶ In the most recent example, the UK has announced a new strategy called “Health is Global” which sets a course for increasing financing to strengthen health systems with an emphasis on universal coverage, health workforce, access to essential interventions, patient safety, non-communicable diseases and injuries, and sexual, reproductive and maternal health.¹⁷ This largesse at the global level has also been accompanied by increased national spending on health in many middle-income developing countries, e.g. India and China.¹⁸

Despite this financial windfall, and in spite of the articulation of a set of principles for more effective and equitable aid delivery, in the form of the Paris and Accra Declarations on Aid Effectiveness¹⁹, it is disconcerting to note that the current landscape is characterized by fragmentation, lack of coordination and even confusion as a diverse array of well-funded and well-meaning initiatives descend with good intentions on countries in the developing world.²⁰ Many of these initiatives are narrowly focused on specific diseases (e.g. HIV/AIDS, malaria and TB) rather than systems-wide strengthening, tend to be “top-down” in nature and are largely driven by donor agendas rather than the country's own

needs and priorities. Many of the initiatives also lack mechanisms of accountability, transparency and evaluation in the way they operate within countries²¹, and tend to focus on short-term results - thus raising a real question about future sustainability. Internal brain drain, as manifested by loss of health workers from the public sector to better funded initiatives and NGOs offering better remuneration, has been highlighted as a particularly serious problem. Although some efforts are ongoing (e.g. in relation to the Global Fund to Fight HIV/AIDS, TB and Malaria which has started to fund health worker costs) much more needs to be done on evaluating the impact of multiple initiatives on national health systems.²²

Many of these initiatives pose a real burden on the capacities of countries to absorb the health aid and, “instead of representing prioritized contributions to sustainable change, funds are simply fueling an ‘aid industry’ of fragmented assistance.”²³ In 2008, a group of former ministers of health and senior health officials from developing countries identified three current challenges in global health financing and governance arrangements²⁴: too many initiatives - donors need to learn to “stay the course”; national strategies are being weakened by parallel priorities and implementation directed largely by donors; and limited transparency and information on activities and inadequate reporting on the part of donor agencies. Anecdotally, it has been reported, for example, that a district medical officer in Tanzania spends 25 full days per quarter writing reports for various agencies which provide development aid to the health sector.²⁵ Health improvement in the developing world is arguably not just about throwing more and more money at the problem although some such as Jeffrey Sachs might contest this. It is rather about how to use the money most effectively to improve health in a sustainable manner. There is thus a consensus among academics and policy-makers that current models and mechanisms are inadequate to meet the challenges and, arguably, represent a failure of governance arrangements. Such concerns have been expressed since the late 1990s when Lee²⁶, for example, stated that “we must rethink the goals and activities of present institutions” and more recently by Sridhar²⁷ who stated that GHG needs to deal with three significant changes in the global health system in the past two decades, characterized as being “too many players, too many initiatives”, “go-it-alone bilateral aid,” and the “Gates empire.”

Accordingly, it has been pointed out that there is a “growing demand for new governance architecture for global health,” and that the “desire for governance reform is widespread, if not epidemic”²⁸. The call for review and rationalization has also been extended to the field of global health research governance.²⁹ Amidst questions such as “do we have the architecture for health aid right?”³⁰, and calls for a “Bretton Woods II” summit, there has been no shortage of vigorous debate and discussion in this field in terms of possible options and alternatives for better GHG, often drawing on the subject of global governance more generally.

INNOVATIONS

A variety of different models and mechanisms have been proposed as possible improvements or as complements to current modes of governance. These range from informal to formal, from conceptual to pragmatic and from “soft” to “hard” instruments with many permutations and combinations in between. Some examples will be highlighted.

Within the WHO, the leading international health agency, there has been an increasing use of “harder” instruments³¹ e.g. the revised International Health Regulations (IHR) and the Framework Convention on Tobacco Control (FCTC) which both came into force in 2005.³² In spite of ongoing challenges in the implementation of these international legal instruments³³ there continues to be interest in this approach as exemplified by a proposed role for global administrative law³⁴ and, in the public health field, a proposal for a Framework Convention on Global Health.³⁵ Both the IHR and the FCTC represent the outcome of extensive inter-governmental processes coordinated by the WHO which reflects the strong interest of sovereign states in global health issues, and a desire on their part to have a voice in the development and implementation of appropriate governance mechanisms and instruments.

Most recently, the ongoing Intergovernmental Meeting on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other benefits (PIP-IGM) is attempting to deal with fair and equitable sharing of influenza vaccines.³⁶ In the recently concluded 124th Session of the WHO Executive Board, counterfeit medicines, migration of health personnel, and health partnerships were other examples of important global issues where WHO Member States expressed a desire for a stronger voice through a more inclusive consultative process, including the possibility of formal mechanisms such as formal consultations and inter-governmental working groups.

In addition to the WHO, the role of major global institutions, in particular the World Bank and the G8 has been the subject of recent interest.^{37,38} In the post-Wolfowitz era, there appears to be some enthusiasm for the World Bank's new strategy for health, population and nutrition which seems to focus on the institution's strengths and comparative advantage in terms of its established relationship with developing country governments. In its annual summit in 2008 in Tokyo, the G8 gave prominence to global health issues but it has been criticized as being unrepresentative in that eight countries controlling 65 percent of world output represent only 13 percent of the world's population.³⁹ To make it more representative and reflective of current realities, it has been suggested that a new G8 could be formed by Brazil, China, the European Union, India, Indonesia, Japan, Russia and the USA, or perhaps there should be a move towards the G20 forum.⁴⁰

Taking a more regional approach, Kickbusch and Matlin have proposed the idea of establishing a European Council on Global Health which “would seek to influence policy and improve practice through advocacy-based evidence and analysis.”⁴¹ They envisage that such a council could become part of an alliance of similar councils in different parts of the world. This idea has recently obtained funding from the UK’s new “Health is Global” strategy.⁴² The regional approach is also reflected in the idea of trans-governmental networks, which focus on relationship building to collectively solve important issues.⁴³ Examples of such regional platforms could include ASEAN, the European Community, MERCOSUR and the newly formed UNASUR in Latin America.⁴⁴

Moving from a geopolitical to a more issue-based approach, the influential World Economic Forum has proposed the formation of “Global Agenda Councils” for each major world challenge which will provide objective and expert advice, objective situational assessments and recommend solutions to major global problems.⁴⁵ Such councils would act to support and advise existing governance structures and would not aim to replace them. More recently, the governments of Germany and France propose the convening of a Berlin Evolution of Medicine Summit which are envisaged “to inform and advice governments, policy makers, health-care professionals, and business leaders worldwide.”⁴⁶

In an attempt to provide a unified structure, and taking into account the clear links between health, poverty and development - and acknowledging the increasingly global and inter-sectoral nature of health problems - Horton has proposed the creation of a World Development Organization as a form of GHG.⁴⁷ The purpose of such an organization would be as an advocate for further attention and funding as well as a scientific and technical agency for human development which would set standards for development work and coordinate bilateral and multilateral development aid and programmes.

In acknowledgement of the important role of market forces, Kaul has suggested that a new system of global governance should be composed of a series of issues or global public goods-centred policy “loops” which stretch from the national to the international level and back to the national level.⁴⁸ Kaul’s view seems to support the importance of taking advantage of market dynamics as a one of the key “drivers” of governance which should be supported by promoting innovative financing mechanisms such as the advance market commitment (AMC) and the International Finance Facility for Immunization (IFFIm). Continuing along the vein of “techno-fixes”, but focusing on the increasing scientific capacity of developing countries like India, Brazil and China, Mahoney and Morel propose that a global health innovation system could represent a novel GHG model to plan, coordinate, conduct and support efforts to develop and deliver new technologies for diseases which primarily affect the poor in the developing world.⁴⁹

In contrast to the models and mechanisms described so far, Fidler questions the preoccupation with structures (and the use of the term

“architecture”, stating that that “the architecture metaphor begins to look inapt”) and, in the context of “unstructured plurality” which characterizes GHG today, proposes that global health should instead adopt a “source code”.²⁸ The challenge for GHG is to effectively apply the “source code” in various areas affecting health, with the efforts in each “then inform(ing) the evolution of the source code, producing an expanding network of actors, processes, ideas, and initiatives that shape global health governance”. Similar sentiments have been expressed by Walt⁵⁰ who argues that the architecture analogy is misplaced “because it draws our attention to structures and global level discourses, and away from actors, interests and values, and country level implementation”.

Two recent GHG innovations are also worth a mention. First, and in the context of market failures to develop drugs for the poor⁵¹, an attempt has been made at developing a global, market-based, systemic solution to health challenges faced by the world’s poor. The recently launched Health Impact Fund is presented as “an optional mechanism that offers pharmaceutical innovators a supplementary reward based on the health impact of their products, if they agree to sell those products at cost.”⁵² The proposed Fund would be financed mainly by governments. Second, UNITAID, “a laboratory for innovative financing,” has collected over \$600 million in less than 2 years mainly through an air travel tax, has reduced the price of anti-retrovirals by 40 percent and is also funding the supply of diagnostics and treatments in 38 developing countries.⁵³

ATTEMPTS AT COORDINATION: THE WHO AND IHP+

It would be fair to state that the models and mechanisms described above are not mutually exclusive and overlaps exist but the plethora of diverse initiatives point clearly to the lack of coordination, direction and accountability as three of the key challenges facing GHG today.

Given the lack of coordination and accountability among numerous global health initiatives, Garrett has suggested that “the only organization with the political credibility to compel cooperative thinking is the WHO.”⁵⁴ Strong leadership is urgently needed and as the leading international public health agency representing 193 sovereign states, WHO “is uniquely positioned to provide this leadership by virtue of its role in setting evidence-based norms on technical and policy matters, highlighting best practices that improve health globally, and monitoring and coordinating action to address current and emerging global health threats.”⁵⁵ This statement from a recent Institute of Medicine Report advising the new US administration on global health, goes on to state that “the US President should demonstrate support for the WHO as a leader in global health.”

However, and as pointed out by many, a number of factors have eroded WHO’s ability to be the lead institution in GHG.⁵⁶ It is perceived to be bureaucratic and inefficient, subject to political pressure from its more powerful

Member States, and lacking clear priorities among a multitude of programmes. There is also a perception that the organization has not been able to deal with the challenges posed by globalization and, as a result, others have stepped into the void. Importantly, it suffers from inadequate resources and the reality that nearly 80 percent of its budget now come from external donors, rather than from assessed contributions from Member States, has brought into question WHO's neutrality and independence. A disjoint has also been highlighted in the way the Organization allocates its resources with budget allocations heavily skewed towards infectious diseases (87 percent) with non-communicable diseases and violence and injuries receiving only 12 percent and 1 percent respectively.⁵⁷

However, and despite reservations of the role and effectiveness of international organizations, the WHO, in the view of some, should be "reinvented" and not be the victim of "early retirement".⁵⁸ In the GHRG field, WHO has been involved, for example, in improving transparency and access to the results of clinical trials globally through the establishment of an International Clinical Trials Registry Platform (ICTRP).⁵⁹ It played a critical coordinating role during the SARS outbreak in 2003 and the new influenza A (H1N1) crisis in 2009, and has been the main driver behind the success of two GHG instruments (the IHR and the FCTC). It is also a key player in convening the International Health Partnership and Related Initiatives (IHP+).

An earlier initiative to establish better coordination and alignment of GHI's, referred to as the H8⁶⁰, has now been extended to the IHP+.⁶¹ The IHP+ is an attempt to bring 23 countries, 13 organizations and civil society to work together in partnership to improve health outcomes through a single, harmonized in-country implementation strategy. At the centre of this strategy is the "country compact" where development partners work in the context of existing in-country mechanisms through a single, costed, results-oriented national health plan with the objective of scaling-up effective coverage as a means of achieving the targets set by the health-related MDG's. To date Ethiopia, Mozambique, Nepal, Rwanda and Uganda have signed the country compact and other countries are in the process of doing so. In terms of the financial stream, the IHP+ recently launched a High-level Task Force on Innovative International Financing for Health Systems with the UK government, for example, pledging a £500 million contribution.

GLOBAL ACTION NETWORKS

An additional model for coordination are cross-sectoral Global Action Networks (GANs).⁶² Described as a mode of governance involving authoritative negotiations between state and non-state players which have interests and capacities to influence and shape outcomes in specific issue areas, GANs usually start with a focus on "techno fixes" around small, centrally structured networks but they then develop and shift their focus to building social relationships and

effecting deeper change, subsequently evolving into decentralized, polycentric networks. GANs have been described as “functional responses to gaps generated by processes of globalization that states and the extant inter-state system cannot fill,” and also possess the ability to bring into the picture other key players.

GANs are an innovation that have the potential of robustly filling the ever widening gaps in global governance. In theory and increasingly in practice, GANs seize the opportunities to address global problems in an increasingly interconnected world that international agencies, governments, businesses and civil society organizations acting separately have proven unable or unwilling to meet. Filling this “global governance as global problem solving deficit” lies at the functional core of their missions.

Since the end of the Cold War which created a major window of opportunity for global governance experimentation, and particularly over the last decade, more than five dozen GANs were established and new ones are being created in virtually every issue area. Prominent examples of initiatives in the global health field that can be categorized as GANs include the Global Fund, GAVI, GAIN, the Stop TB campaign among others. The Global Fund, despite its numerous problems, is arguably one of the most innovative cross-sectoral financing arrangements in global health of the past two decades and has dramatically increased the resources directed towards addressing HIV/AIDS, tuberculosis and malaria worldwide.

Not all global partnerships focused on health or in other fields aspire to be or will become GANs. GANs as an ideal type share a set of strategic principles:

- Being truly global and multi-level (working transcontinentally if not worldwide across the local, national, regional and international levels of governance and bridging extant divides such as North-South, cultures, nations, sectors, ethnicities, genders).
- Implementing interdisciplinary action-learning and reflective action to produce otherwise unattainable results by attaining synergies between knowledge and practice (through a range of strategies including agenda setting, knowledge generation/sharing, capacity building, resource mobilization, conflict resolution, public education, and certification among others).
- Building enduring yet nimble multi-stakeholder and cross-sectoral, inter-organizational *networks* (linking international agencies, governments, businesses, civil society organizations and other actors while still utilizing hierarchies or markets as appropriate)

GANs are innovations whose legitimacy is being forged by optimizing democratic imperatives (transparency, participation and accountability) and effectiveness (adaptability, efficiency, and scalability). The underlying theory of change of GANs is animated by a view that effectiveness in global problem solving requires all legitimate and consequential actors to be coherently linked in

order to scale impact and generate the systemic changes that are needed.

GANs must be understood as having two levels of outcomes. One is a collectively defined goal or goals that all participating organizations can buy into. It derives from the fundamental rationale for founding a GAN—the need to bring together distinctive competencies and resources on a global scale. This first level of outcome may be called a “system-organizing” goal—GANs can be thought of attempts to organize diffuse activities of many organizations into a new global “system”. For example, the Global Reporting Initiative aims to bring together diverse stakeholders to create a global system of corporate reporting.

This over-arching goal is seemingly broad, but it must support the particular objectives that lead organizations to participate in order for the GAN to be successful and sustainable. Unilever and Walmart participate in the Marine Stewardship Council not only to develop sustainable fisheries, but to develop those that will also be profitable for it. Success in a GAN is determined by collective commitment to both the over-arching goals, and to support for individual stakeholders to reach at least some of their own objectives. This emphasizes the importance of clearly articulating these two different sets of goals and ensuring collective commitment to them.

Three initiating paths for GANs can be distinguished. One emphasizes a period of two to three years of consultation with the various stakeholders followed by an initiating meeting of some sort, in a sense like a constitutional convention. A second group of GANs have begun out of the imagination and usually as a program of one or a couple of organizations. The third path is appropriate when there is already a relatively well-developed “global space” for the participants. For example, global conferences on the topic of water issues were organized from time-to-time which led to the realization that more formal and permanent organizational arrangements would be valuable. This led to the formation of the Global Water Partnership and the World Water Council.

In general, successful GANs follow a development path from a centralized model where the role of a “Secretariat” dominates to a polycentric network with many dispersed hubs of activity communicating with each other. However, in some cases, the centralized model may be simply a conscious and strategic choice; for example, when the principal function involves distribution of funds as with the Global Fund and the International Youth Foundation. In some cases the GANs get “stuck” at a development phase with a centralized model; this reflects the difficulty of shifting to the higher development stage which demands a new way of thinking about organizing.

GANs also change their focus in addition to their structure. As the diverse stakeholders work together, new ways of thinking about the issue emerge—one of the most remarkable examples is the shift from defining climate change as an outgrowth of overpopulation of the South, to defining it as an environmental impact footprint of people living in the North. Participants generally start out with a “techno-fix” or specific operational improvements as the goal. For

example, leading participants often come from a problem-solving perspective and think about their issue in terms of developing appropriate solutions and getting others to buy into the solution they have developed. They think of the challenge as creating the “right” code of ethics, or the “right” physical technology to respond to a question such as energy and climate change, or the “right” way to build human capacities. Only as they work together do they start to understand that the critical challenge is also about creating social relationships and processes where they can work effectively together in the face of dynamically changing circumstances, challenges and opportunities.

This is certainly a challenge GANs are still facing as they often try to bring together policy makers, scientists/specialists, community activists and business people, among many others. Although the evidence-based promise of GANs is significant, their legitimacy and effectiveness nevertheless remains constrained. On the one hand, their ability to realize their development potential is being limited by a need for more broad-based understanding, support and engagement by the full range of stakeholder groups. On the other hand, the human competencies and institutional capacities to develop the full potential of GANs need to be greatly strengthened. GANs correspondingly may be likened to the same stage of the development of the multinational corporations in the mid-19th century, or international organizations in the aftermath of World War II. Another continual challenge for most GANs is to ensure the equal involvement of and “ownership” by stakeholders from the global south across sectors: government, civil society and the private sector. In the field of global health, this is largely the case. Nevertheless, GANS have been an important innovation in recent years in global governance.

POSSIBLE FUTURE GLOBAL GOVERNANCE ARCHITECTURES

Before turning to what a global health governance architecture might look like, it is useful to turn to global governance more broadly. At least seven possible global governance architectures compete for ideological hegemony if not institutional pre-eminence in the contemporary world.⁶³ These models include: 1) multilateralism, 2) market governance, 3) grassroots globalism, 4) multiple regionalisms, 5) world statism, 6) networked governance, and 7) institutional heterarchy. These models are clearly internally diverse, by no means fully articulated, nor mutually exclusive or necessarily exhaustive. The overview below offers an initial survey of these models for further refinement and debate: all can be seen to be at work in the field of global health governance.

Multilateralism is by far the easiest global governance architecture to see and various versions of it are arguably the most discussed, advocated, and practically applied today. In its minimal desirable form, this model entails truly functioning and formally equal “sovereign” states covering the planet, all fulfilling more or less rule of law procedural standards internally. Through

transparent, participatory, and accountable processes of principal-agent delegation and monitoring from citizens to states to inter-state organizations (IOs) embedded in well articulated regional or worldwide inter-state regimes (IRs - norms, rules, decision-making structures and processes), challenges and opportunities facing the world society of states (and their citizens) are addressed fairly, effectively and efficiently.

Multilateralism has two generic sub-types. The first is what might be called state-centric multilateralism. In this case global governance is primarily shaped by the agreements and coordinated behavior of national states. The primary mechanisms for this form are the various G's - the G8, G20, G24 and G77 for example. In this variant, inter-state organizations (IOs) play primarily a supportive and secondary role to national states. In the second form of multilateralism on the other hand, IOs play much more of a lead role. The more central position of IOs might be the result of greater delegation by national states, greater legitimacy and capacity on the part of the IO or IOs in that field, or both. This sub-model thus might be called IO-centric multilateralism.

Market governance is predicated on either the assumption that well functioning and unfettered global markets are the best allocation mechanisms for a globalizing world. More often than not, it is argued, governance through markets will produce progress and order through innovation and competition. A slightly more nuanced justification for the market governance model is that market imperfections even when they occur are still more desirable forms of governance than state intervention because of the even greater likelihood and pernicious effects of state failure. In other words, a world governed by somewhat imperfect markets is certainly better than a world governed by widespread state failures.

But the theory and practice of market governance is not always seen in opposition to states. Many scholars and policy-makers argue that the primary role of states (with their IOs and IRs) is to foster and catalyze better functioning markets. States should also utilize market mechanisms rather than command and control mechanisms if and when regulation is required and to promote social and environmental goals that are not automatically delivered by markets. Finally, other actors such as private sector firms and civil society organizations can, do and should promote market governance through voluntary corporate citizenship efforts and forms of regulation that often can bypass the state altogether.

Grassroots globalism involves at least the extreme de-centering of territorial bureaucratic national states and extant IOs and IRs, and replaces them with peoples organizing anew in self-governing local communities. It entails radical decentralization of authority relations to the "local" level through processes of direct participation in all spheres of political, economic, and social life. This deep democratization is also predicated on eliminating the centrality of markets and multinational corporations in favor of modes of production, distribution and consumption that combine the best features of socialist,

solidarity and ecologically embedded economies. Dynamism would be ensured through empowered citizen participation for the continual reinvigoration of societies, especially through the cyclical emergence and waning of transgressive social movements (feminist, ecological, etc.) from time to time.

Moving to a higher governance level than the local, one could imagine a world of *multiple* cooperative regionalisms. One key notion in this model is that the pre-dominant locus of authority would not be national states but rather at various regional collectivities of political units (states or other forms) and societies. An important facet of this model is that these regional collectivities would not primarily or all be states themselves just governing larger geographical territories. The regions could be territorially smaller or larger, organized differently or similarly, but all would meet minimum thresholds of democratic decision-making and institutional capacity. The regions could be more or less self-contained but would cooperatively interact with each other to the extent that trans-regional problems or opportunities arose. One could also imagine the emergence of inter-regional organizations and regimes in a world of multiple cooperative regionalisms.

There also remains the enduring possibility of a world state, more or less legally constituted and governed. The range of possible institutional arrangements of a world state is potentially limitless and can draw heavily on the long traditions of theorizing and experimenting with “sub-planetary” sovereign territorial political regimes. At the center of the notion of a world state would, however, be the notion that citizens would acquire their ultimate rights and owe their ultimate responsibilities to a global, formal, and centrally organized authority with worldwide reach.

A world state would require a planetary military-security establishment with a “monopoly of force”, unless the possibility of complete demilitarization is achieved. Even then, some form of police force with worldwide reach would certainly be needed. It would also have a universal tax collecting agency for it to be considered a state in the most minimal sense. The Universal Declaration of Human Rights, along with the set of ratified, international treaties could likely be the base constitutional framework for a world state. This world state could have a planetary assembly, planetary executive, planetary court, planetary bank, etc. One could imagine various forms of democracy (parliamentary, presidential, etc.), and forms of federalism with subsidiary territorial units (either homogeneously or heterogeneously) assembled together or constituted anew. Alternatively, or in some mixed form, functional domains (a planetary corporatism?) could be the organizing basis of this world state. And various permutations could be imagined.

Models of networked governance come in two versions – the trans-governmental and the multi-stakeholder or cross-sectoral. Proponents of both espouse that networks can provide the appropriate balance between the efficiency of decentralized markets, the authority of hierarchical states, and the

accountability of democratic systems required for a complex, high-paced and deeply interconnected world. These networks are likely to cross levels of governance but can be either ad-hoc or institutionalized. The key difference between the two types is the nature of the actors that constitute the networks -- in the transgovernmental image it is primarily state governmental and bureaucratic agencies (although not just from central states), whereas in the multi-stakeholder variant it is state engaged with non-state actors from various sectors (e.g. private sector firms, civil society organizations).

In the trans-governmental image, horizontal and vertical networks of governmental officials and agents (e.g. central bankers, judges, legislators, ministers, generals) from disaggregated states share information, increase capacity and coordinate activity to manage global affairs. In the multi-stakeholder variant, networks of relevant actors from across sectors (public governmental, private business and private non-profit/non-governmental in particular) join together in dynamic institutional arrangements to address global challenges and seize global opportunities in different domains of social life. Global Action Networks (GANs) that combine the comparative advantage of groups from across multiple sectors and are themselves potentially linked together fill critical gaps in global governance. States and inter-state organizations are still important but varying and not always predominantly so.

Institutional heterarchy involves a world of multiple types, forms and levels of authoritative political organizations and units (communities, religions, interest associations, epistemic communities, companies, states, inter-state organizations, social movements, regions, transnational or global networks of various kinds, etc.), and various types and levels of governance. Individuals or groups would simultaneously participate and consider themselves members and/or citizens of several of these. All individuals and collectivities would be subject to an evolving but not overriding global constitutional and legal framework.

Another way of thinking about institutional heterarchy is to imagine a legitimized and formally combined multi-layered (MLG) and poly-centric (PCG) set of territorial and functional governance arrangements. 'MLG can be defined as an arrangement for making binding decisions that engages a multiplicity of politically independent but otherwise interdependent actors – private and public – at different levels of territorial aggregation in more or less continuous negotiation/deliberation/ implementation, and that does not assign exclusive policy competence or assert a stable hierarchy of political authority to any of those levels.' In contrast, "PCG can be defined as an arrangement for making binding decisions over a multiplicity of actors that delegates authority over functional tasks to a set of dispersed and relatively autonomous agencies that are not controlled – *de jure* or *de facto* – by a single collective institution."

While other possible global governance architectures are analytically possible and worth considering, this initial mapping above offers a continuum of

potential futures that have been espoused as desirable by actually existing groups and coalitions. Empirical traces of each of these seven clusters are more or less in existence in the contemporary historical period with grassroots globalism and world statism being the least empirically discernible - and certainly in the area of global health. But no one of them is fully consolidated and unequivocally legitimated. Rather these models are hotly contested.

CRITERIA FOR GOOD GLOBAL HEALTH GOVERNANCE

Reflecting on the global governance more broadly, and informed by experiences with existing GHG and GHRG arrangements, some criteria may be defined for improved mechanisms of GHG. Regardless of what model is most appropriate or effective, and assuming that “no one size fits all” will be the rule, it is proposed that future mode(s) of good GHG should possess six key criteria.

First, GHG has to be the outcome of a series of balancing acts between the needs of national and global governance, including consideration of regional needs. On this point, it has been stated that “...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 only have limited effectiveness”.⁶⁴ It also has to achieve a balance between formal and informal mechanisms, and between market forces and demands for social justice and equity.

Other balancing acts are needed. Between a focus on specific diseases of immediate public health concern and a holistic, systems strengthening approach, and between legitimacy, democracy, participation on one hand, and effectiveness on the other as well as between ideas and theories of governance, and the realities of implementation, i.e. the need to actually “make it work”. Between learning from past successes (and failures), and acknowledging the need for innovation on future governance needs in the context of a new political era and continued pressures from globalization, both positive and negative.

Second, GHG has to be inter- and trans-sectoral in nature and adopt a multi-sectoral and multi-disciplinary approach. Global health governance cannot exist in isolation within the health sector and must be cognizant of, and linked to, other initiatives - it should aim for “health in all governance”, embracing other key sectors including trade, agriculture, diplomacy, labour, law and environment.

Third, it has to be inclusive and embrace the diversity of interested parties and stakeholders, and be able to “listen to wider voices”. It has to be sensitive to local context, needs, capacities and knowledge and how these fit within the wider framework of global norms and standards. As pointed out by Fidler, the current diversity and plurality of actors, interests, norms and financing modes may actually possess future governance potential.⁶⁵ Listening to wider voices also means acknowledging the contributions of local knowledge and experiences in

governance, as exemplified by preparedness for epidemics and pandemics, as well as in building stronger health systems.⁶⁶

Fourth, GHG has to agree on and define the roles and responsibilities of various players based on a shared set of substantive norms and values including ethics, equity, solidarity, democracy and the right to health - and adopt the principles contained in the Paris Declaration on Aid Effectiveness in order to better harmonize and align health development aid.

Fifth, ideally, it has to have a transparent and accountable system of checks and balances and must monitor and evaluate its performance and impact, and give due consideration to issues of sustainability. While this might seem impractical given that the various institutions involved in governance have their own systems of accountability, it is an ideal worth striving towards given the universal benefits.

Sixth, GHG must harness the power of information and evidence to guide its actions by striving for “evidence-informed governance” including promoting research into the topic of GHG itself. This is a relatively neglected research field which faces conceptual, analytic and design challenges and has to sometimes deal with the political nature of the issues.⁶⁷ GHG should also creatively utilize advances in information and communications technologies to gather information and data important for good governance in various areas. The recent reported use of the internet search engines, Yahoo and Google, for influenza surveillance illustrates this point⁶⁸, as well as UNITAID's creative use of on-line ticketing to collect a levy on international airline tickets mentioned previously.

A MULTI-LEVEL APPROACH TO GOVERNANCE

What is the way forward? It has been proposed that several factors should be taken into account: strengthening mechanisms to hold donors accountable for their actions, a focus on developing national plans and strengthening national leadership, and promoting south-south collaboration.⁶⁹ Based on consideration of the above criteria, future needs and current realities, and the fairly obvious need for a flexible and inclusive model, a GHG partnership framework model which is based on a multi-level, multi-purpose and multi-stakeholder perspective where the different layers perform distinct but mutually supportive functions is proposed (Fig. 1). The layers can be envisaged as performing several key functions, including “summitry”-advocacy-coherence, governance-accountability, and technical-operational, and is based on a set of shared values of inclusiveness, democracy, solidarity and equity.

First and foremost, the partnership framework should have high level political commitment, visibility and policy coherence. In this regard, and in the current context of the global financial crisis, the G8, despite its limitations, may have a particularly important role to play in helping to influence and change the global health agenda and its priorities.⁷⁰ Ullrich has also proposed that the G8

may be able to provide a “cure” for GHG by providing much needed multi-level policy coherence within the GHG system through three unique governance mechanisms: mutual accountability, delegation to other institutions, and the “ratchet effect” around convergence of annual meetings of key players (e.g. the World Bank, OECD, IMF).⁷¹ The G8 Summit of 2008 in Tokyo placed health high on the agenda, making commitments to strengthen health systems, improve maternal, newborn and child health, and strengthen countermeasures against infectious diseases.⁷² It is also noteworthy that the MDGs have remained on the agenda for the G8’s 2009 Summit to be hosted by Italy in July 2009.⁷³ However, it is worth noting that in financial regulation and economic governance, the G8 has waned in importance to the G20 as a decision-making and consensus-building forum. A similar shift is occurring in global health governance.

Supporting and complementing the high level entities such as the G8 and G20, a supporting role is envisaged for regional, high-level trans-governmental platforms such as ASEAN, the European Community and MERCOSUR and USASUR in Latin America. These forums could enrich the framework by providing additional, diplomacy-style relationship-building types of mechanisms and processes, both formal and informal, which complement the more traditional, western-oriented normative approaches. Regional platforms based in the developing world could also play an important role in promoting south-south collaborations for health improvement as has been seen, for example, with Cuban doctors working in Africa and the close collaboration among ASEAN countries after the 2003 tsunami.

At the next level, and linked to its delegation mechanism, the G8, or possibly G20, should ensure the presence of a strong backbone for the partnership framework in the form of an effective, inclusive, and transparent governance mechanism with some form of formal executive “power”. The WHO, as the leading international health agency could provide such a governance platform – “while it is far from perfect, there seems little doubt that the WHO should be the leader, and given certain reforms, it could manage the chaotic and crowded landscape and play a key role as coordinator”.⁷⁴ Despite the prevailing sentiment that the WHO could not take on such a political task, perhaps this is an opportune time to revisit the issues, especially in the renewed interest for reform expressed in the recent IOM advisory to the new US administration.⁷⁵ WHO can arguably play a central role in ensuring that the potential for positive synergies which exist between health systems, research for health and the global health initiatives are vigorously exploited by all stakeholders to ensure maximum, mutual added value. In this regard, the proposal for the formation of a Committee C of its World Health Assembly⁷⁶, which will aim to improve “consistency of global health action and coordination”, is worth considering.

In terms of a possible mechanism, the establishment of a “Committee C” of the World Health Assembly (WHA) could take a step towards achieving this objective. Article 18 of the WHO constitution gives the Organization a legitimate

role to “ensure more transparency and debate between global health players.” Committee C would complement the existing Committees A (which deals with programmatic-technical matters) and B (which deals with budget and managerial matters). The proposed committee would bring together WHO Member States, major global health initiatives and other key stakeholders (e.g. civil society) in an annual, formal platform to strive for better coordination, alignment and harmonization. It would, in the standard *modus operandi* of the WHA, operate through proposing resolutions for adoption but “to explicitly welcome within such resolutions commitments independently taken by other partners that would be annexed to the resolution.”⁷⁷ Critically, however, and to overcome major concerns over such a structure disempowering developing countries⁷⁸, the voting power to pass resolutions should be solely vested in the Member States, thus preserving their autonomy and independence in the governance of WHO. While Committee C would not address the underlying problem of the WHO which is that it is heavily reliant on voluntary contributions and thus vulnerable to donor priorities, it would take a step forward at addressing the democratic deficit within the WHO, as well as provide a platform for the various global health actors to meet annually. While the actual form of “Committee C” needs much more discussion and reflection, what it is ultimately attempting to address is the chaos in the global health system and the leadership role the WHO could assume.

At the technical-operational level, the most appropriate conceptual framework are the GANs due to their flexibility, their focus on building social relationships, their inherent iterative learning capacity, and their potential for catalyzing needed change. The areas in which GANs should be active could be discussed and agreed upon at the Committee C of the WHO and their actual, in-country implementation would then depend on a broad spectrum of implementing instruments including public sector agencies, private sector entities (including public-private partnerships) and civil society-NGOs. The function of the GANs is therefore to define a broad mission, e.g. “...to save children’s lives and protect people’s health by increasing access to immunization in poor countries” (for GAVI), and the mission would, in turn, define the types of possible implementing modes at the national level. One could also envisage different GANs defining different missions across the spectrum of contemporary health challenges, with the concept being especially suited to having an inter-sectoral focus, e.g. addressing the social determinants of health.

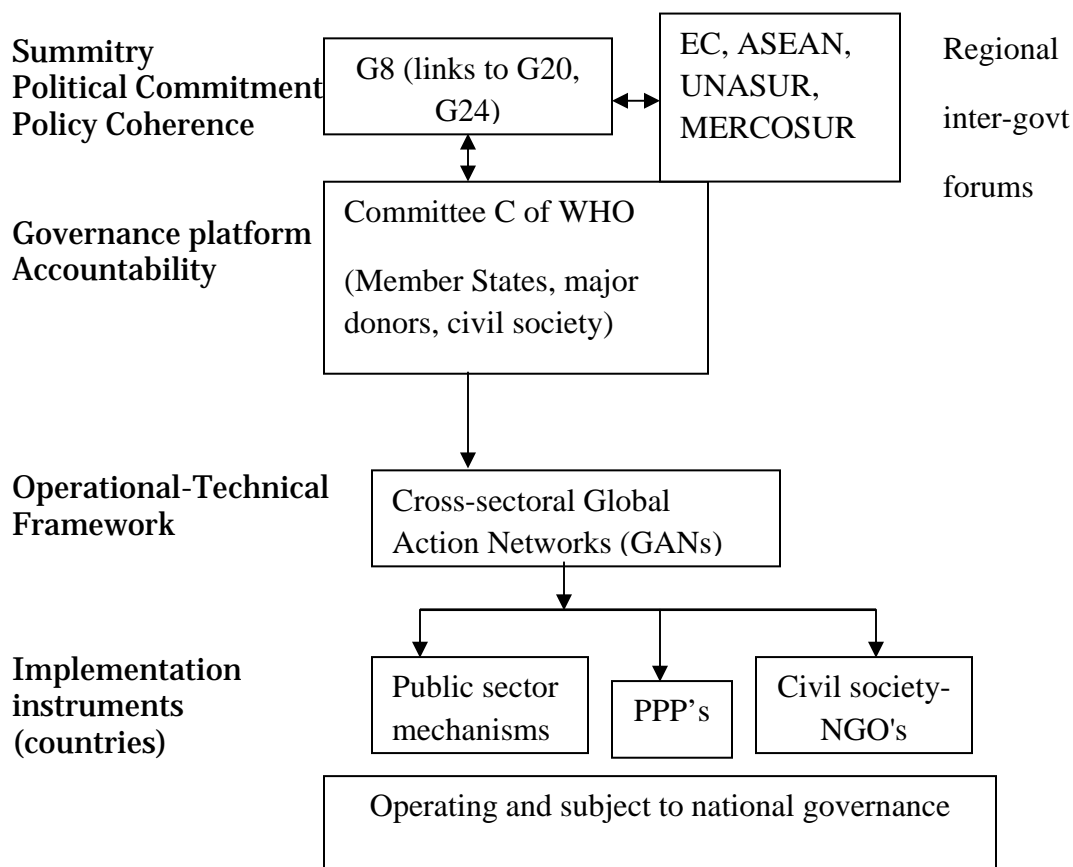
Three important directions should be taken in relation to GANs to improve the field of global health problem solving and global governance. The first is to support the further development of global health GANs that already exist such as the Global Fund towards the strategic goals of being truly global, action-learning oriented and truly inter-organizational, cross-sectoral networks. The second is the creation and support of new global health GANs such as around the issue of building and strengthening health delivery systems in countries where they are weak or non-existent. The third is to seize opportunities to partner with GANs in

other issues areas that are directly linked to key global health problems and goals. For example, working with the Global Water Partnership on issues of water and health, with the Microcredit Summit Campaign around micro-finance opportunities to improve health access and outcomes, with the Global Knowledge Partnership on improving Information and Communications Technology systems related to health goals, or with the Global Partnership for the Prevention of Armed Conflict to re-frame ending mass violence as at least partly a global health issue.

GANs can also benefit in future from the UN Reform initiative, “Delivering as One.”⁷⁹ This pilot initiative is being tested in eight countries (Albania, Cape Verde, Mozambique, Pakistan, Rwanda, Tanzania, Uruguay and Viet Nam) and its aim is to determine how the UN family – with its many and diverse agencies - can deliver in a more coordinated way at country level. The objective is to ensure faster and more effective development operations and accelerate progress to achieving the Millennium Development Goals. The success of this initiative will depend on overcoming barriers to effective cooperation that exist within the UN, demonstrated by the difficulties that UNAIDS has experienced.⁸⁰

In the context of broader models and categories of global governance, the proposed partnership framework (Fig. 1) probably fits what has been described as “institutional heterarchy”⁸¹ which involves a variety of “multiple types, forms and levels of authoritative political organizations and units and various types and levels of governance.” In our view, the proposed framework addresses and satisfies some of the key criteria for good GHG. It acknowledges sovereignty (of both Member States and other key stakeholders)⁸², diversity and multiple layers of governance; it is inclusive, transparent and has shared values and, above all, it provides a single, democratic and inclusive coordination platform with an accountability element, arguably two critical requirements in today's complex landscape. Importantly, and rather than creating totally new structures, it makes use of existing institutions and their current mandates. It is also important that emphasis is placed on obtaining results. Something akin to a global public health “scorecard”⁸³ should perhaps be developed for GHG.

Ultimately, however, the success of the proposed framework must be predicated on the development of a shared overarching vision which focuses more on the “why” and less on the “how”. The functions of governance has been outlined and debated extensively, and the nuances, permutations and mechanisms of various governance models are a fertile field of academic study in and of itself. But what is ultimately important is that “global health governance is about global problem solving”⁸⁴ and its “why” is primarily about developing good national governance in order to strengthen health care delivery systems in the developing world. When global health governance has, and embraces, a shared “why”, it can bear with and accommodate almost any “how”⁸⁵ in its quest to deliver health and health equity to disadvantaged populations in the developing world.

Figure 1. Partnership framework for global health governance.

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