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Action on global health: Addressing global health governance challenges

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A change in perspective

Despite progress in many areas of global health action there is an increasing consensus that it is insufficient and too slow. It was hoped throughout the last 10 years that an approach targeting specific diseases would move global health a significant step forward, but we are again at a stage where it is becoming clear that our response must be based on another intellectual premise. This insight is best expressed by Inge Kaul, in her seminal work on global public goods: *the pervasiveness of today's crises suggests that they might all suffer from a common cause, such as a common flaw in policy making, rather than from issue specific problems. If so, issue specific responses, typical to date, would be insufficient—allowing global crisis to persist and even multiply.*[1]

A change in perspective implies that we approach the global health crisis[2] not primarily as a set of disease-based challenges but as a challenge on how to ensure health as a global public good through a reliable mechanism of global governance. This means we need to gain an understanding of the political determinants of global health and seek to analyze the 'common flaws' most relevant to policy making in the global health arena. Two such flaws gain particular prominence:

- the lack of a long term commitment—at all levels of governance—to institution building for health, including sustainable financing and strengthening of human resources as part of the health development agenda; this reflects the need to reform the practices of the donor community,
- the weak political commitment and fragile institutional and organisational base—at all levels of governance—to address the global production of health risks as part of a new global health policy agenda; this reflects the need to develop new mechanisms which support the production, protection and financing of global public goods.

At present, the dominant perspective applied to global health action is organized around issue specific problems, usually specific diseases such as AIDS, malaria and tuberculosis. The unresolved debate within the global health world whether to put the priority on issue specific (vertical) or systemic (horizontal) measures, has come back into focus as major disease based initiatives are faced with the lack of human resources and delivery systems in the developing world.

On the one hand, some disease based approaches have shown extraordinary success, the most well known of course being the eradication of smallpox.

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A recent publication of the What Works Working Group[3] analyzes 17 selected global health success stories throughout the developing world ranging from eliminating polio in Latin America to improving the health of the poor in Mexico and preventing iodine deficiency disease in China. Piecemeal projects, argues the economist William Easterly, have led to significant improvements in reducing infant mortality and increasing access to clean water at the community level.[4]

On the other hand, even the What Works Working Group expresses frustration with the fact that many of the successes have not been replicated and scaled up to the extent that would seem reasonable and expected given their high impact on the health of populations. Just recently, the World Health Organization and UNAIDS were forced to announce that their goals of '3 by 5'—to treat three million people with HIV by the end of 2005—would not be reached, mainly due to shortages of health workers and problems with drug supplies.[5]

Frustration has turned to pessimism and anger in many other areas of global health. For example, the broad public awareness of the significance of health action in the developing world has been created largely through the information on HIV/AIDS and its devastating consequences in the poorest countries of Africa. But after 20 years of global advocacy, high political profile—even making HIV/AIDS the first ever health issue to be discussed at the UN Security Council—and millions of dollars in aid, the lack of progress in fighting the epidemic is obvious. In view of the fact that there are an estimated 25 million HIV positive people in Africa and that the disease is wiping out many of the development gains of recent decades, Stephen Lewis, the UN Secretary General's special envoy on HIV/AIDS in Africa, has expressed his sentiment in the following way: There are no excuses left, no rationalizations to hide behind, no murky slanders to justify indifference—there will only be the mass graves of the betrayed.[6]

A new political ecosystem

In order to understand some of the governance issues that need to be addressed we need to consider the new political ecosystem of health with its new set of actors and redirection of functions, the new political space it embodies, and the new quality of its politics. This system of global health governance deserves closer analysis than it has received so far, not only in the public health world but also in the field of international relations, as it constitutes an excellent example of the development of transnational society at the end of the 20th century. Public health research will increasingly need to incorporate not only epidemiological evidence but move into compiling new types of evidence related to policy and implementation—this inevitably relates to the analysis of the distribution of power and resources within and between countries and different actors.

A redirection of global health functions

The most striking development in the international arena has been the increase in the number of transnational actors. Global health is different from international health in that it defines itself through a complex interplay between state and non-state actors and through new organisational mechanisms that allow for their involvement. The new global health system is clearly pluralistic and characterized by increasing privatisation: functions which in the international health system would have been dealt with through interstate mechanisms or/and international/multilateral organisations such as the WHO. They are now more commonly conducted by other types of organisations such as an increasing array of public-private partnerships. A prime example is the important role played by the Bill and Melinda Gates Foundation, which pump as much money into the global health system as the regular budget of the WHO. The Initiative on Public-Private Partnerships for Health (IPPPH) lists 80 public-private partnerships on its website[7] but informal discussions with staff of the initiative suggest around 150 public-private partnerships in the global health arena.

This redirection of functions and programmes formerly in the public/governmental/interstate arena towards private organisations has significant consequences in terms of priority-setting, ownership, control and accountability. It has clearly reduced the importance of the UN system—some would say it is a reflection of its failures to respond adequately to the challenges at hand. William Easterly[4] sees the present development as a positive move away from what he deems to be the weak accountability of international agencies for their 'big plans' and programmes towards a focused intervention-based accountability of 'visible piecemeal steps'. He also suggests that a more pluralist system will provide developing countries with intervention choices that they do not have when confronted with the 'Cartel of Good Intentions' of

development agencies and their comprehensive plans.[8]

What he does not address is the downside of this development, which also leads to what can be termed the Balkanisation of global health. The term is used to describe the process of fragmentation or division of a region into many smaller regions that are often hostile or non-cooperative with each other.[9] In the global health arena a multitude of actors now competes for funds, media attention and legitimacy—and while many of these initiatives will have helped make a difference on the ground, they have not helped to create reliable infrastructures for health and have frequently put additional burdens on developing countries through complex application and reporting procedures. Nancy Birdsall[10] in a recent analysis of the 'seven deadly sins' of donor behaviour provides the example of Tanzania, which in the period from 2001 to 2002 had 1300 foreign aid based projects, 1000 donor meetings a year, and had to produce 2400 donor reports every quarter. She underlines that such 'collusion and coordination failures' undermine the governance capacity of countries and indicate the need for 'ambitious and structural changes in the overall aid architecture'.

A new political space

Not only have the actors in health increased exponentially, the situation is rendered more complex by the fact that within the last decade health has entered a new political space. It is present in a broad range of governance arenas and global health is no longer in the remit of only the ministers of health as part of their responsibilities within the deliberations of the WHO. The recognition and acceptance that health is not only an outcome of development but contributes significantly to economic growth, social stability and individual life chances, as put forward for example by the Commission on Macroeconomics and Health,[11] has made health part of many larger, more comprehensive policy initiatives. The recognition of new infectious disease threats through outbreaks or bioterrorism has raised the profile of health in security policy. The relevance of epidemics in relation to failed states and loss of social cohesion has made it a concern of foreign policy. Intellectual property agreements have put health on the agenda of trade policies. Global health advocates are now active in writing briefs for meetings such as the World Economic Forum, the National Economic Partnership for African Development (NEPAD) or the G8 meetings.[12]

The Millennium Development Declaration and its goals which were agreed in 2000 by the heads of state in the context of the United Nations give health high prominence.[13] Three of the goals refer explicitly to health outcomes: reducing under five mortality, reducing maternal mortality, and reversing the spread of HIV/AIDS, malaria and TB. Health features in some of the sub-targets, in particular the target related to water and sanitation and the target on access to essential drugs.

As global health moves out of the technical domain into other policy arenas the ideological differences in the basic premise of global health governance approaches become more prominent and we can witness a shift from the technical analysis of health risks into more politically driven assessments from viewpoints such as national security, market opportunities or global social justice.

A different quality of international health politics

But beyond the sheer quantitative increase in the number of actors and the new policy space we also experience a changed quality in the global policy arena.

First, it becomes more and more difficult to draw borders between different fields of action, which until now have been assigned to different ministries at the national level and to different organisations at the international level. Indeed, one consequence has been that it is more difficult to define what is domestic and what foreign policy. But, even more importantly as some would argue, health has not only moved into other 'harder' policy arenas, but it has also gained a new type of strength and relevance. As an increasing number of health issues now have relevance to foreign and security policy, health moves from being defined as low politics to high politics.[14]

Second, the very nature of politics has changed from elites to one that involves ordinary people. Global Health issues have become an ethical driving force promoting the idea of a common humanity. The women's health movement and the HIV/AIDS movement were at the forefront of insisting that health is indivisible and that every life, no matter where on earth, has the same value. This has taken global health into the realm of popular global culture where pop stars have played a prominent role in setting global agendas such as 'Make poverty history'. While many are skeptical, if not downright cynical, about such efforts they do reflect a new level of awareness of global health issues that was

not present in earlier generations. Barry Buzan,[15] in his analysis of the social structure of globalization, has termed this the interhuman domain, in which ordinary citizens accept a global frame of reference.

Globalisation has also provided 'opportunities for groups such as women, lesbians and gay men, disabled persons, indigenous people to mobilize to a degree that was generally unavailable to them in...territorial politics'.[16] Increasingly, therefore, the interstate system is cross cut by an array of networks, alliances and partnerships focused on 'identity politics...based on ethnicity, class, religion, sex, sexuality or other criteria'.[17] The movements for reproductive rights or HIV/AIDS are obvious examples - and they have clearly changed the priorities set in the global health arena.

Third, these movements are usually loosely coupled networks, driven by moral politics and supported by modern information technology. Manual Castels has defined networks as the organisational form of the 21st century and sees them as the appropriate instruments for a capitalist economy based on innovation, globalisation, and decentralised concentration.[18] Networks also respond to what has been called the globalisation paradox: expanding global governance capacity without centralising policy-making power.[19]

The role of public health associations

Nation states are usually seen to have four major functions: security, rule of law, social welfare, and identity and participation. These functions have clear equivalents at the level of global governance: human security and human rights, international rule of law/global ethics, fairness in global distribution, common identity as global citizens and a global voice and channels of participation. Health risks in the 21st century are obviously transnational - both as regards infectious and non-infectious diseases as well as the determinants of health. Indeed transboundary issues and collective human security issues gain increasing importance. Global risk production is localised through the globalisation of everyday life—no aspect of how we 'live, love, work and play'[20] is free from a global dimension—be it the food we eat, the advertising we see, the information we access or the fears we have. As a consequence, the development of international norms and standards as well as compliance, transparency and accountability (CTA) gain increasing importance.

Examples in the health arena are the International Health Regulations and the first ever treaty signed in international health, the Framework Convention on Tobacco Control. What emerges is that accountability in health is widened to include the national and local constituency as well as the global constituency, a fact well illustrated on the occasion of the recent SARS epidemic. But the notion of CTA needs to be widened beyond nation states and international organisations to include the wide range of actors in the global health arena. Very first steps are underway in the corporate social responsibility arena, supported by the UN Global Compact.

Networks—both advocacy networks and technical networks—contribute significantly to the compliance with global norms through network effects that support the transfer of 'rules, practices, institutional structures'.[21] But this is not sufficient. At present there is no mechanism whereby the various actors within the pluralist global health system are held to account. A first analytical attempt is being made by the people's Health Movement through the Global Health Watch alternative health report to be published in July 2005.

National public health associations (NPHA), as important technical networks, will need to move their activity into the CTA arena and be at the forefront of explaining and exploring the interface of national and global public health agendas. A global domestic policy agenda could include:

- Reform and strengthen global institutions and international law for health
- Control unsafe goods and products, ensure corporate social responsibility
- Ensure access to essential medicines, vaccines and health knowledge and research
- Increase human capacity and health literacy
- Create primary health care and public health infrastructures, surveillance and information systems
- Create professional capacity and ensure human resources
- Fight major diseases and defined global health emergencies including rapid response.

One mechanism to do this could be to organise national Global Health Summits based on a national global health strategy and a national global health report based on CTA indicators. In this manner NPHA could set out the dimensions and parameters of such a global governance debate. NPHA will need to engage in the policy arenas into which health has moved and seek to understand their goals

and ensure that public health principles and values remain present. As global health becomes both high politics and a key concern of global citizenship,[22,23] NPHA have a unique historical opportunity to step out of the shadows and develop intellectual leadership in the five action areas of the Brighton declaration:[24]

- health as a global public good
- health as a key component of collective human security
- health a key factor of global governance of interdependence
- health as responsible business practice and social responsibility
- health as global citizenship.

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