

Chapter 7

Global Governance

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1. Introduction to the Concept of Global Governance

We live in an interdependent world. The dynamics of the global interdependence of nations and peoples have led to the emergence of global challenges, such as global warming, transnational spread of infectious diseases, pollution and climate change, illicit drug trade and obesity. These new challenges defy the classic Westphalian inter-state system¹ by disrespecting the geo-political boundaries of nation-states. As a result of the globalization of the world's political economy, policies at the "domestic-foreign frontier" (Rosenau, 1997) now converge and intermesh in a seamless web of global governance. The idea of global governance was popularized in the 1990s through the work of the Commission on Global Governance (1995), and the emerging discourse in international relations (Rosenau Czempiel, 1992). Governance is defined as:

"... the sum of the many ways individuals and institutions, public and private, manage their common affairs. It is a continuing process through which conflicting or diverse interests may be accommodated and co-operative action may be taken. It includes formal institutions and regimes empowered to enforce compliance, as well as informal arrangements that people and institutions either have agreed to or perceive to be of interest" (Commission on Global Governance, 1995).

The concept of global governance does not imply that nation-states have become irrelevant, nor does it denote a centralized enforcing authority as a global government. Instead, global governance postulates the emergence of multiple actors – states, regional and international organizations, charitable foundations, non-governmental organizations, civil society, and private sector interests like multinational corporations and international business associations – that now share power, influence, and authority in the cross-national dealings (Aginam, 2005; Bettcher & Lee, 2002; Mathews, 1997). Because of the absence of a centralized enforcing authority at the global level, global governance is not synonymous with government (Rosenau, 1997). The effectiveness of governance rule systems (Rosenau, 2002) derives from traditional norms and habits, informal agreements, shared premises, and "as the demand for governance increases with the proliferation of complex interdependencies, rule systems can be found in

non-governmental organizations, corporations, professional societies, business associations, advocacy groups, and many other types of collectivities that are not considered to be governments” (Rosenau, 2002)

In an age of globalization, global issues can only be effectively regulated through a combination of a state-centric system driven by governments and a “multi-centric system” driven by a collection of non-state actors. State and non-state actors compete, cooperate, and interact (Rosenau, 2002) and the proliferating centers of authority on the global stage are now composed of actors, large and small, formal and informal, economic and social, political and cultural, liberal and authoritarian, who collectively form a highly complex system of global governance. Examples of governance frameworks based on the state-centric system include multilateral conventions, treaties, regulations, standards, and soft law declarations. These are negotiated and adopted by states either among themselves as the dominant actors in international relations, or by states under the auspices of Westphalian international organizations like the United Nations, World Trade Organization, World Health Organization, and the Food and Agriculture Organization, which admit only states as members.ⁱⁱ Multi-centric system frameworks cover regulatory approaches to global issues that either are driven by non-state actors or involve their active participation along with states in the form of public-private partnerships.

This chapter assesses the relevance of global governance to population health by focusing on the new International Health Regulations adopted by the World Health Assembly of the World Health Organization (WHO) in 2005 and by exploring the dynamics of public-private partnership, including discussion of the specific example of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

2. Global Governance and Population Health

The World Health Organization’s ambitious definition of health as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity” (WHO, 2001b) links public health to a range of other public goods in the global context (Grad 2002; Kaul, Conceicao, Le Goulven, & Mendoza, 2003; Smith, Beaglehole, Woodward, & Drager, 2003). The link between global governance and population health is driven by the phenomenon of globalization, a process that intensifies transcontinental risks and networks and adds cognitive, temporal, and spatial dimensions to global interdependence of markets, peoples and nations (Lee & Dodgson, 2000). In the health context, globalization underscores a complex web of interrelated risks and opportunities that affect the well-being of populations in rich and poor countries (Arhin-Tenkorang & Conceicao, 2003; Taylor, Bettcher, & Peck, 2003). In an interconnected world “bacteria and viruses travel almost as fast as e-mail and financial flows” (Brundtland, 2003). Globalization of public health concerns includes the challenges of infectious and non-communicable diseases in an interdependent world (Lee & Dodgson, 2000; Woodward, Drager, Beaglehole, & Lipson, 2001; Yach & Bettcher 1998a,b).

Beyond infectious diseases, tobacco marketing, environmental degradation, alcohol and illicit drug use, anti-microbial resistance, hunger and food insecurity, diet and obesity now constitute worldwide health threats.

Globalization has altered the governance architecture of global health through transformation of the spatial organization of social relations (Held, McGrew, Golblatt, & Perraton 1999; Scholte, 2000). The regulatory approaches to transnational spread of disease and other health threats pose enormous challenges that are beyond the governance capabilities of individual nation-states. Erosion of the traditional distinction between national and international health threats means states are no longer the sole actors or stakeholders in negotiating effective solutions to transnational health threats. The traditional use of treaties, regulations and formal regimes, mostly by states within international organizations like WHO, still plays an important role in global governance because countries have always used international law to solve problems that are transnational in nature (Aginam, 2005; Fidler, 1999; Kaul et al., 2003; Taylor et al., 2003). However, the globalization of public health has catalyzed emerging global health governance involving states, international organizations and non-state actors (Kickbusch, 2003). Gomez-Dantes (2001) observes, “the actors who traditionally dominated the global health arena – national governments, the World Health Organization (WHO), and various NGOs – have been joined by development banks, aid agencies, and other private sector groups who wish to shape the response to the threat of disease.”

Because of the multiplicity of actors in global health governance, the implementation and coordination of global health policy have become exceedingly complex (Gomez-Dantes, 2001). One recent governance framework that links global governance and population health is the World Health Organization’s new International Health Regulations (IHR).

2.1. International Health Regulations

In May 2005, the World Health Assembly of the WHO adopted the new IHR to provide the regulatory framework for WHO’s global public health surveillance (Baker & Fidler, 2006). The fundamental principle of the IHR is to ensure “maximum security against the international spread of diseases with a minimum interference with world traffic.” The new IHR replace the old IHR adopted in 1951. The 1951 Regulations were narrow in scope as they applied only to three diseases: cholera, plague and yellow fever. The old IHR, a legally-binding set of regulations adopted under the auspices of WHO, represent one of the earliest multilateral regulatory approaches to global surveillance for infectious diseases.

Under the old IHR, WHO member states that accepted the Regulations undertook to notify the organization of an outbreak of any of the three diseases in their territories. Notifications sent by a Member State to WHO were transmitted to all the other member states with acceptable public health measures to respond to such outbreaks. The old IHR listed maximum public health measures applicable

during outbreaks, and provided for rules for international traffic and travel. These measures covered the requirements of health and vaccination certificates for travellers from areas infected by these three diseases to non-infected areas; deratting, disinfecting and disinsecting of ships and aircraft; and detailed health measures at airports and seaports in the territories of WHO member states. The old IHR were ineffective as a global health regulatory tool mainly because they were based on a classic inter-state framework. WHO had no powers to operate pro-actively and could only use information given by Member States.

The new IHR codified ambitious proposals that mark a radical shift from the traditional inter-state governance framework to global governance that would involve non-state actors. This move stemmed from the complex ways in which globalization is propelling the emergence and re-emergence of epidemics (Aginam, 2004; Baker, & Fidler, 2006; Fidler, 2005). The new IHR formalized a duty of each state to notify WHO of “all events which may constitute a public health emergency of international concern within its territory.” On the basis of information received, particularly from the state party within whose territory an event was occurring, Article 12 authorizes the Director-General of WHO to determine whether an event constitutes a public health emergency of international concern. The determination shall rely on scientific principles as well as available scientific evidence and other relevant information, including consultation with the state party in whose territory the event is occurring and information from non-state actors.

The most difficult task facing the WHO is identifying optimal methods to manage the IHR in the unfolding post-Westphalian public health architecture. Practically, WHO must respond to the realities of the present international system, in which nation-states are still the dominant, but no longer the sole actors in international relations. As codified in the new IHR, WHO’s global public health surveillance must transform from traditional state-centered approaches to a “post-Westphalian” global health governance (Fidler, 2004) – a combination of formal and informal governance tools that directly involves states as well as international organizations, civil society, and non-governmental organizations.

The new IHR enables the WHO to develop global governance strategies by making use of information derived not exclusively from WHO member states, as is the case with the old IHR, but from relevant non-state actors. These global governance strategies were effectively deployed by WHO during the 2004 Severe Acute Respiratory Syndrome (SARS) outbreak when WHO collaborated with the global community of epidemiologists and with civil society to contain the crisis (Aginam, 2004; Fidler, 2004). Besides SARS, the IHR’s application to “all events which may constitute a public health emergency of international concern” links WHO’s Global Outbreak Alert and Response Network (GOARN) to emerging epidemics and pandemics such as avian and pandemic influenza. The WHO has recently set up an advisory Task Force linked to the IHR on potential public health issues of international concern related to avian and pandemic influenza, including issues such as the appropriate phase of pandemic alert, the declaration

of an influenza pandemic, and appropriate international response measures to a pandemic. The IHR are a key element in strengthening global health security and a platform for sharing knowledge and the ability to respond to rapidly-evolving emergencies globally. The IHR complement existing technical partnerships and networks of global disease surveillance (WHO, 2006). The Regulations also offer a framework to enable WHO to collaborate more effectively with other non-state actors during health emergencies.

2.2. Public-Private Partnerships

Another way to explore global governance in the context of population health is the gradual but steady proliferation of public-private partnerships (PPPs) involving international organizations, states, and non-state actors. These partnerships operate on a range of health issues: malaria, vaccines and immunization, tuberculosis, polio eradication, HIV/AIDS, and trachoma (Buse & Walt, 2000a,b, Buse & Waxman, 2001; Pinet, 2003). Global PPPs for health are “those collaborative relationships which transcend national boundaries and bring together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed and explicitly defined division of labour” (Buse & Walt, 2002). Examples of global PPPs that involve the private sector, corporate entities, civil society organizations, inter-governmental organizations, and states include the Global Alliance for Vaccines and Immunization (GAVI), Stop TB Initiative, Roll-Back Malaria Campaign, Medicines for Malaria Venture, and International Partnership for AIDS in Africa.

The extent to which PPPs affect population health outcomes directly has been debated primarily because some PPPs are “product-based partnerships” that consist mainly of drug donation programs in developing countries while the others are “systems/issue-based partnerships” that assist governments in strategizing and harmonizing approaches and raising profiles of single diseases in global health policy (Buse & Walt, 2002). Global health PPPs have been the subject of critical and analytical discourses that assess their fairness, legitimacy, accountability and transparency (Aginam, 2002; Buse & Walt, 2002; Yamey, 2002). As Buse & Walt (2002) observed, the widespread adoption of PPPs in global health policy raises challenges, including the need for “more empirical research on the institutional features that make such partnerships effective. Such empirical work should also aim to identify more generally applicable, good practice guidelines, including principles for ‘good partnership governance’ (transparency, accountability, etc.)” In the absence of good practice guidelines, PPPs are accountable to no one. This has largely been the case with the Roll-Back Malaria Campaign and the Medicines for Malaria Venture (Aginam, 2002; Yamey, 2002). The proliferation of PPPs, although valuable, should not be confused with optimal effectiveness for global health governance.

2.3. Global Governance of AIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria

As the WHO Commission on Macroeconomics and Health (World Health Organization, 2001a) observed, health is inexorably linked to poverty reduction as well as to long-term economic growth. Evidence in support of these linkages is powerful and much stronger than is generally understood. The mortality and morbidity burdens of disease in some low-income regions, especially Africa, impede economic growth and therefore must be addressed centrally in any comprehensive development strategy. The HIV/AIDS epidemic, for instance, represents an unprecedented urgency that can undermine Africa's development over the next generation.

With over 40 million living with HIV globally and new infections accelerating, especially in developing countries, the epidemic of HIV/AIDS has challenged the traditional international health governance framework. In a single decade, the governance of HIV/AIDS has shifted from a program within the World Health Organization (Global Program on AIDS) to a joint venture program of nine United Nations system organizations (the UNAIDS), and is presently the subject of a global PPP financing facility – the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (Poku, 2002). The Global Fund was conceived mainly by the G8 summit as a PPP to promote an integrated approach emphasizing prevention in a continuum of treatment and care for HIV/AIDS, tuberculosis and malaria. These three diseases are poverty-related, with the heaviest burdens in developing regions of the world where the public health systems are weak and vulnerable populations cannot afford effective therapies. Therefore, the Global Fund was intended as a funding facility to compliment existing multilateral organizations, especially WHO, World Bank, and UNAIDS.

Based in Geneva, Switzerland, the Fund is a public-private collaborative financial instrument, and not an implementing agency. It is an alliance of partners from the United Nations agencies, developing countries, donor governments, foundations, corporations and non-governmental organizations, and people living with HIV/AIDS (Bartsch, 2005; Brugha & Walt, 2001). The Fund is built on basic principles that include the creation, development, and expansion of government, private and civil society partnerships and the promotion of consistency with international law and agreements and respect for intellectual property rights. At the time of its inception, it was estimated that the Global Fund would need about \$7–10 billion annually to combat HIV/AIDS alone, and would obviously need more resources for tuberculosis and malaria. The Global Fund, as a PPP, has emerged as an important player in global health governance by bringing together states and non-state actors in decision-making processes nationally and globally (Bartsch, 2005).

Since its establishment in 2002, the Fund has become a leading financing mechanism for tuberculosis and malaria treatment and prevention, distributing 66% and 45% of all international funding for the two diseases respectively, and 20% of all international funding for HIV/AIDS (Bartsch, 2005). Still, the Fund is

not without serious problems. One challenge for the Fund is donor fatigue; donors must be mobilized to redeem their past pledges and sustain future financial commitment to the Fund. As well, Barstch (2005) has rightly observed that the Fund “must try to handle one problem typical for public-private partnerships: the existing tensions between a vertical approach in fighting specific diseases and broader horizontal approaches in health system development and the promotion of public health.” Nonetheless, the Global Fund has since its inception attracted US\$ 4.7 billion in financing through 2008. It has committed US \$ 1.5 billion in funding to support 154 programs in 93 countries worldwide. This has enabled many countries to scale up existing programs (Global Fund, 2006).

3. The Future of Global Governance for Public Health

This chapter discussed the relevance of global governance strategies to the transnational spread of diseases and health threats and argued that the traditional Westphalian governance model, while still relevant, is limited by the globalized challenges of disease-control initiatives in an interdependent world. Communicable and non-communicable diseases have both become global health issues that require new global governance strategies. The complex transcontinental networks created by the phenomenon of globalization, when applied to the global health context, are compelling enough to catalyze fresh insights on the best ways to regulate transnational spread of diseases. The codification and implementation of global health accords is becoming increasingly important as global health interdependence accelerates and nations increasingly recognize the need to cooperate to solve essential problems. Governance of global health requires collaboration between international organizations with “overlapping” mandates, such as WHO, UNAIDS, Food and Agriculture Organization of the United Nations, World Bank, World Trade Organization and many others, along with both state and non-state actors. It also requires cross-disciplinary work among scholars and researchers in public health and epidemiology, clinical medicine, international relations and international law, demography and economics, anthropology, social work, and development.

Endnotes

- i. The Westphalian international system emerged from the Treaty of Westphalia, 1648, that ended thirty years of war and conflict in Europe and led to the emergence of nation-states as the primary actors in international relations. Applied to public health diplomacy, membership of multilateral health organizations like the World Health Organization is open only to states, and only states can become parties to multilateral health treaties, conventions, and regulations negotiated under the auspices of those organizations.
- ii. There are numerous treaties, conventions, agreements, regulations, declarations and soft-law adopted by states under the auspices of these international organizations. While some are health-specific, others affect health in different ways. Examples include the long list of human rights and environmental treaties and conventions negotiated and adopted by states within the United Nations system; the World Health Organization’s

Framework Convention on Tobacco Control (FCTC); The World Health Organization and Food and Agriculture Organization's jointly administered Codex Alimentarius Commission standards on food safety; and the trade agreements enforced by the World Trade Organization, especially the Agreements on Trade-Related Aspects of Intellectual Property Rights (TRIPS), Sanitary and Phyto-Sanitary Measures (SPS), Technical Barriers to Trade (TBT), and the General Agreement on Trade in Services (GATS).

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