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Towards a radical transformation in global governance for health

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The Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) is an emerging global movement to dramatically improve global health, with particular attention to the needs of the world's least healthy people. The original idea for JALI began in the spring 2008 in Washington, DC when Harald Siem led a Norwegian delegation to Georgetown University Law Centre to discuss the idea of a Framework Convention on Global Health (FCGH). The FCGH idea, which has now been incorporated into JALI, proposed a dramatic reform of global governance for health to harmonize fragmented global health activities, meet basic survival needs, and ensure health funding (both domestic and global) is predictable, sustainable for the long-term, and scalable to needs. In this article we discuss JALI and the FCGH in the context of the United Nations call for global health reform, arguing that the international community must take a radically different, bold approach to global governance for health.

The *Joint Action and Learning Initiative on National and Global Responsibilities for Health* (JALI) is an emerging global movement to dramatically improve the public's health, with particular attention to the needs of the world's least healthy people (1). Partners from civil society and academia announced JALI in an editorial in the *Bulletin of the World Health Organization* (2), together with a major background paper for the *World Health Report 2010* (3). The first global stakeholders meeting was convened in Johannesburg in March 2011, with another planned for India later this year.

JALI, however, did not begin in 2010, but rather in March 2008 in Washington, DC, when Harald Siem led a Norwegian delegation to Georgetown University Law Centre to discuss the idea of a Framework Conven-

tion on Global Health (FCGH), which was initially proposed by one of the authors (LOG) (4). The FCGH idea, which has now been incorporated into JALI, proposed a dramatic reform of global governance for health (GGH) to harmonize fragmented global health activities, meet basic survival needs, and ensure that health funding (both domestic and global) is predictable, sustainable for the long-term, and scalable to needs. No one in the world is more passionate about global health equity and no one understands more the vision for a transformative system of global governance. Harald's eyes are glowing and keen, his insights astute, and his enthusiasm infectious.

On 17th March 2010, with the leadership of Sigrun Møgedal and John-Arne Røttingen, The Norwegian Directorate of Health convened a global consultation on the topic, 'Examining the Global Health Arena: Strengths and Weaknesses of a Convention Approach to Global Health.' The Framework Convention approach received its first serious scrutiny there (5), and at this meeting, the idea for JALI was born. In this article, dedicated to Harald Siem, we argue that the international community, with World Health Organization (WHO) leadership, must take a radically different, bold approach to global governance for health.

The contemporary history of global governance for health

Until recently, GGH has not captured significant international attention. Part of the reason may be that much of the global health landscape was for decades uncrowded, with several leading institutions and dominant themes, which could largely be examined on their own terms—for instance WHO and primary health care (the Declaration of Alma-Ata) and the World Bank (structural adjustment). Governance could largely be understood through a relatively limited set of institutions and approaches. This relatively simple understanding of global health, and its governance structures, is no longer true.

Beginning in the 1990s and accelerating in the 2000s, the global health landscape expanded swiftly. The number of actors proliferated, with bilateral agencies, nongovernmental organizations (NGOs), partnerships, foundations, corporations, and new multilateral institutions such as the Global Fund and GAVI. AIDS came to dominate the global health landscape, while the Millennium Development Goals (MDGs) drew particular focus to maternal and child health. The burden of non-communicable diseases rapidly grew in developing countries. Globalization gathered speed, contributing to the faster international spread of disease, while increasing the impact on health, trade, migration, and the environment. International funding for health grew exponentially, although funding is still outpaced by need. Health

systems moved up on the global health agenda, while primary health care, the social determinants of health, and universal health coverage commanded renewed attention.

Non-state actors (such as NGOs, foundations, and partnerships), not the traditional subject of international law, have come to the fore. The roles of intergovernmental institutions that have dominated the field of global health have been in flux or in retreat, while some have questioned the leadership of the WHO. As other legal regimes have matured, some have encroached upon global health's territory. They have even collided with efforts to address principal global health challenges, as most prominently evidenced in the tension between international intellectual property and access to essential vaccines and medicines.

Global governance is struggling to catch up, to effectively respond to this changing environment. Across much of the global health landscape, binding international health law may appear secondary, or simply absent, with notable exceptions such as the Framework Convention on Tobacco Control and International Health Regulations. In domains occupied by several bodies of law, such as where health and trade intersect, there is no consensus on a hierarchy of regimes that could resolve conflicts. Seeking to fill the void and resolve these tensions are ad hoc arrangements with less obvious connections to international law. The 'soft law' of non-binding instruments and structures have emerged as more relevant approaches for governing a sometimes-chaotic global health landscape, such as the Paris Declaration on Aid Effectiveness, the International Health Partnership, the Global Fund, the WHO Global Code of Practice on the International Recruitment of Health Personnel, and the Doha Declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement and public health.

Meanwhile, innovative proposals to re-order the global health landscape to lead to better health appear at odds with traditional views of international law. Local and national priorities must drive actions for better health, 'bottom-up' approaches rather than the seemingly 'top-down' imposition of international law. Treaties typically take years to negotiate, and years more still to come into force, a timescale that may appear to be eons in today's world full of pressing health needs. Furthermore, international law is notoriously difficult to enforce. Are the answers to what is widely agreed to be flawed and outdated global governance for health structures to be found in international law, or elsewhere? Would a more organic, less structured set of processes be more responsive and better able to meet the complex, fast changing challenges of global health?

Global governance for health, including international law, has the potential to dramatically improve global health. It can bring effective governance to presently poorly governed parts of the global health landscape. Developed astutely, especially if backed by social movements, international law and GGH can provide a frame that is sturdy yet flexible, constructed of human rights and social justice, shaped by community needs and priorities.

Seeking to learn from its present strengths and weaknesses, we will offer a vision of how effective governance can respond to today's global health needs, shape far more efficient institutions and structures, close health inequities, and manage emerging challenges. We hope to inspire confidence – and the aspiration – to engage in the further development of GGH, to help unleash its power, and to pursue the ideals behind it.

Global governance for health: A definition and differentiation

The United Nations system has focused attention on GGH, acknowledging that the concept 'is increasingly being challenged by new realities of an interdependent world and that there is an urgent need to make the global health architecture more effective, efficient, and responsive, in order to, inter alia, bring more coherence to the delivery of health outcomes and enhance health equity.' (6) Indeed, the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, founding members of the Foreign Policy and Global Health Initiative, argued in September 2010 that '[f]oreign policy areas such as security and peace building, humanitarian response, social and economic development, human rights and trade have a strong bearing on development and have an important interface with health.' (7) The United Nations, moreover, has specifically linked health and foreign policy, urging member states to 'consider health in the formulation of foreign policy making … to contribute better to creating a global policy environment supportive of global health.' (8)

What does 'global governance for health' mean, and how can it be differentiated from similar concepts such as international health law generally and 'global health governance' in particular? We define GGH as the collection of norms, institutions, and processes that collectively shape the health of the world's population. It encompasses structures at the international level, such as the norms created by major treaties in the health (e.g. the International Health Regulations and Framework Convention on Tobacco Control) and related sectors (e.g. TRIPS and the Kyoto Protocol); the international organizations that affect global health (e.g. WHO, World Bank, and World Trade Organization); and global decision-making bodies and

processes (e.g. the World Health Assembly and Global Fund grant-making process).

Global governance for health encompasses the dynamic relationship between global structures and forces and those at regional, national, and sub-national levels: how they inter-relate and influence norms, institutions, and processes at all levels, including at the community level. GGH also includes how, in turn, more local structures affect global structures and processes. For example, virtually all states have infectious disease laws, which must comply with the International Health Regulations. The International Health Regulations, in turn, also feeds into national and local structures, for example, by mandating capacity building with international cooperation and assistance.

Scholars sometimes use 'global governance for health' interchangeably with 'global health governance,' but the former term is broader and therefore more desirable. 'Global governance for health' refers to the broader governance system's influence on health outcomes, including multiple sectors such as health, trade, food, labour, human rights, and the environment. 'Global health governance,' on the other hand, refers to the narrower form of governance that is encapsulated by the boundaries of the health sector. Notably, the recent statement of the seven foreign ministers of the Foreign Policy and Global Health Initiative used the term 'global governance for health' (7).

Rules play a critical role in global governance for health. Such rules can range from legally binding agreements (e.g. public international law relating to human rights or trade) to non-legally binding instruments such as declarations, codes of conduct, and memoranda of understanding (e.g. WHO Code of Practice), through to institutional bylaws (e.g. the organizational structure of the Global Fund or GAVI Alliance). Understanding, applying, and shaping the law are therefore central to the task of formulating more effective GGH. These international legal instruments, in turn, are implemented through and otherwise influence laws and legal structures within countries, effects that are also central to understanding the idea of GGH.

Governance does not operate in a vacuum, but is shaped by multiple forces, including politics (globally and nationally), power dynamics (between and among countries of the global North and South), the influence of vested interests (e.g. corporations) and economic power (e.g. the Gates Foundation), security interests (human security and more traditional security interests), changing circumstances (evolving disease burdens and the many changes driven by globalization), knowledge and learning (lessons from

how present structures are affecting global health), and values (e.g. human rights and global ethics). Civil society-led social movements, which are of particular importance in the quest for social justice, powerfully shape governance.

A comprehensive understanding of GGH and of how to wield this potentially powerful tool as a source for better health for all and for health equity, requires sophisticated reflection on the 'grand challenges' that face the global health system, and the inability of the current architecture to meet the critical needs of the world's least healthy people.

The grand challenges of global governance for health

The intractability of progress in global health can be attributed to a number of 'grand challenges'–the enduring, hard-to-solve obstacles that persist in the political, legal, economic, and social contours of the current international landscape and prevent the achievement of global health with justice. Here, we briefly discuss six 'grand challenges' in relation to GGH, which are vital to the improvement of world health and the reduction in glaring health disparities (9).

The lack of global health leadership

The first grand challenge relates to the lack of WHO leadership in its role as the premier agency for global health. The United Nations endowed the agency with extensive normative powers to proactively promote the attainment of 'the highest possible level of health,'(10) including the power to adopt conventions and regulations. The WHO has been an admirable organization, but has failed to live up to expectations in establishing global priorities and norms, coordinating activities, and ensuring compliance of state and non-state actors. The WHO Executive Board itself recommended that the organization better achieve its 'primary function as the directing and coordinating authority on international health work,' and the Director-General recently launched a reform program that will review WHO's role in global health governance, its budget and priorities, and its organizational design (11).

This void in leadership is explained significantly by structural and power dynamics. The politics of WHO are formidable. Not only do Member States and external funders direct funding, but also the agency feels the need to gain broad agreement of Member States to support its mission, priorities, and goals. Otherwise, particularly powerful states could influence, or even block, activities that the agency would otherwise wish to pursue. WHO's ability to change is constricted by limited budgetary resources and compe-

tition with other international agencies for financial support. The ongoing practice by Member States to earmark funds has transformed WHO into a 'donor-driven' organization and restricted its ability to direct and coordinate the global health agenda (12). For the 2008-2009 biennium, only 22% of WHO's program budget was funded through assessed or fully flexible voluntary contributions, with the remainder of its funding restricted at some level, mostly for highly specified purposes (13). Consequently WHO's operations have become increasingly fragmented and compartmentalized so that donors can claim credit and assert control.

Harness the creativity, energy and resources for global health

The proliferation of global health actors (e.g. NGOs, business, philanthropy, and civil society) can be beneficial, as it brings great wealth and creativity into the field. The goal, of course, is not to have these actors disengage, but rather to fully engage them in ways that are well coordinated and highly effective. It is an enormous missed opportunity when all of these stakeholders enter the global health arena in scattered, sometimes conflicting, ways. What is most important is for the governance system to harness the energy, resources, and creativity of all these actors to work together to significantly improve global health.

The GGH system needs to devise the means to create incentives as well as facilitate, coordinate, and channel the activities of state and non-state actors. It needs to enhance health-producing activities and discourage harmful ones. How, for example, can the GGH system increase the involvement of the non-health sectors (e.g. food, energy, and transportation) and encourage them to think in health-conscious ways? Overall, the GGH system needs to find a way to create and align the incentives for private/public actors and stakeholders to promote imaginative, well-funded solutions for global health improvement.

Collaboration and coordination among multiple players

Collaboration and coordination among the multiple players in global health is a critical problem in global health efforts. A number of actors, beyond the traditional state-centric governance system, now occupy the field of global health, resulting in rampant problems of fragmentation and duplication in the sea of funding, programs, and activities that span the global health domain. Such problems have crippling effects at the national level where developing countries 'face a bewildering array of global agencies from which to elicit support,' overburdening health ministries with 'writing proposals and reports for donors whose interests, activities, and processes some-

times overlap, but often differ' (14).

Related to fragmentation among the current proliferation of actors is the growing competition between international NGOs and local service for funding and human resources. This encroachment of international actors upon capable actors at the local level may hinder efforts at greater country ownership and control.

Rather what is needed is a system of governance that fosters effective partnerships and coordinates initiatives to create synergies and avoids destructive competition at all levels – international, national, and local (15).

Basic survival needs

The attainment of fundamental human needs through the development of scalable and sustainable health systems and infrastructures is a seriously neglected problem in global health. Meeting fundamental human needs is essential to restoring human capability and functioning. Basic survival needs include sanitation and sewage, pest control, clean air and water, tobacco reduction, diet and nutrition, essential medicines and vaccines, and functioning health systems for the prevention, detection, and mitigation of disease and premature death (16). By focusing on these needs, the international community could dramatically improve prospects for the world's population.

Funding and priority-setting

The problem of priorities in international funding is another key challenge in global health. Currently, a significant amount of funding is directed towards 'specific diseases or narrowly perceived national security interests' that have been placed high on the global health agenda, often by a small number of wealthy donors (e.g. OECD countries, the Gates Foundation, and Global Fund) (17). As a result, funding tends to be diverted from the larger, systemic approaches, such as building stable local systems to meet basic survival needs.

In priority-setting, a stronger cooperative approach needs to be taken between developing countries and development partners in defining and advancing developing country health agendas. Resource allocation based upon attainment of basic survival needs, support for basic infrastructure and capacity building, and cost-effective interventions have the potential to make donor-funding go further.

Accountability, transparency, monitoring, and enforcement

Finally, there is a critical need for greater transparency, accountability, monitoring, and enforcement in meeting global health goals. Accountabil-

ity in global health has been problematic. WHO and other intergovernmental organizations are officially accountable to their Member States, but 'they often lack detailed and realistic targets for health outcomes or for the intermediate actions they take to promote health' (18). States themselves tend to enter into voluntary, rather than binding, commitments towards health, and it is difficult to hold them accountable under such weak mechanisms. Other actors, such as civil society, foundations and corporations, report to an array of different interest groups and cannot be held accountable for their failures or shortcomings.

At the same time, there is insufficient transparency both with respect to intergovernmental organization and state decision-making. Transparency includes: open governance, free flows of information, and civic participation. These are values that support accountability and are widely believed to be hallmarks of good governance.

Monitoring and enforcement in global health are similarly problematic. Although there have been increased efforts to build monitoring and evaluation systems to track progress, the lack of an enforcement mechanism generally leaves things at a voluntary level for the actors. Reliance on voluntary practice can be unreliable and unstable unless there are adequate incentives to drive performance. All in all, the GGH system needs to adapt by creating rules for accountability, transparency, monitoring progress, and norm enforcement for the fulfilment of commitments and achievement of goals.

The future of GGH

The current approach to GGH has been inadequate. Fundamental health needs continue to be neglected and health systems remain weak. Non-state actors, especially at the local level, are not being sufficiently harnessed through partnerships. The global health landscape has been marked by fragmentation, lack of coordination, and undermining host country ownership of programmes. Transparency and accountability have been poor, and monitoring and enforcement of commitments are almost non-existent. The WHO has yet to assert itself in this new global health environment. Many of these seemingly intractable problems could be solved through innovative governance.

Whether or not Harald's dream of a Framework Convention on Global Health comes to fruition, JALI will transform global health. It will launch a consensus building process, involving research and extensive, inclusive consultations, to address questions that respond to what we view as the core obstacle of global health equity. Governments have failed to develop the

policies and devote the resources needed to more fully apply the substantial body of technical health knowledge, thus enabling all people to have their essential health needs met. JALI will therefore systematically and rigorously examine the questions of what health services are guaranteed to every person under the right to health, what state responsibilities are to their own populations and to those of people beyond their borders in securing the right to health, and what GGH is needed to ensure that all states live up to their mutual responsibilities. We believe that these questions are central to reforming global governance for health so that it is organized to dramatically reduce health inequities.

The time is ripe for reimaging the health responsibilities of states, as the 2015 deadline for the MDGs is looming, and the post-MDG global health framework is yet to be developed. A global health agreement that captures health responsibilities and reforms GGH to enable states and the global health community to effectuate these responsibilities could be attractive to countries of both the global South and North because of the mutual benefits that would come from this approach. For example, it would lead to more predictable global health funding aligned with country strategies, increased domestic health investments that provide wealthy countries the prospect of reducing assistance in due course, and greater capacity to protect everyone from public health emergencies. Such an agreement is not out of reach.

Perhaps most significantly, JALI will transform global health through a global 'bottom-up' campaign. Civil society and governments in the South are demanding a fair share of health goods and services, and the alignment of power structures with the compelling aspirations of the world's least healthy people. A shared common vision of global social justice and realizing the human right to health can unite health advocates from a multitude of perspectives – AIDS advocates and child health advocates, food advocates and safe water advocates, health system strengthening advocates and advocates for health research. This united health advocacy front, with demands for accountability from people's own governments and from the international community, has the potential to turn into a social movement with broad popular support. Such a force will itself be an important chapter in the development of global governance for health.

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