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The Challenges of Global Health Governance

David P. Fidler
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Introduction

Three crises in 2009 revealed the inadequacy of global health governance. The outbreak of pandemic influenza A (H1N1) found countries scrambling for access to vaccines, an unseemly process that led the World Health Organization to call for a new “global framework” on equitable influenza vaccine access. The global economic crisis damaged efforts to achieve the Millennium Development Goals, most of which involve health problems or address policy areas affecting health. The year ended with the fractious Copenhagen negotiations on global climate change, a problem with fearsome portents for global health.¹

Unfortunately, concerns about global health governance are not limited to these epidemiological, economic, and environmental crises. Experts also warned about issues: the failure to prevent HIV/AIDS, antimicrobial resistance, counterfeit drugs, the global prevalence of noncommunicable diseases related to tobacco consumption and obesity, the migration of health workers from developing to developed countries, and the deterioration in the social determinants of health.² Efforts to address these and other global health problems often acknowledge that existing institutions, rules, and processes are insufficient to support collective action.

Ironically, these questions about governance effectiveness have been raised in the wake of a revolution in global health governance over the past ten to fifteen years. This revolution encompassed the creation of radically new regimes, an unprecedented growth in funding for global health, and the growing influence of policymakers, activists, and philanthropists who viewed global health as a foreign policy issue of first-order importance. As a result, global health has become an essential part in the equation of international relations.

In addition to the use of long-standing institutions and well-established international legal regimes relevant to global health, new programs and initiatives emerged, opening the door to both competition and cooperation among states, intergovernmental organizations (IGOs), and nonstate actors. Global health governance innovations include new legal frameworks, public-private partnerships, national programs, innovative financing mechanisms, and greater engagement by nongovernmental organizations, philanthropic foundations, and multinational corporations.

These transformations have produced a complicated governance landscape, composed of overlapping and sometimes competing regime clusters that involve multiple players addressing different health problems through diverse processes and principles. Together, these regime clusters form a global health governance regime complex in which states, intergovernmental organizations, and nonstate actors apply old and new institutions, rules, and processes to strengthen collective action against health threats.

Although unprecedented in international cooperation on health, the current regime complex for global health governance suffers from defects that many experts believe are responsible for suboptimal outcomes for individual and population health. These defects include failures to prevent health problems from becoming global dangers, to produce effective responses to global health threats, to implement important treaties on global health, to develop stronger health systems in developing

countries, and to stimulate sufficient progress on social determinants of health. Many proposals for addressing these defects assume that global health's importance in world affairs will continue at the same level or increase, but the potential for far-reaching reforms in global health governance in the next decade are minimal for many reasons.

The United States will influence how cooperation on health unfolds in the twenty-first century. It provided leadership in the global health governance revolution through expanded foreign assistance, bilateral engagements, regional initiatives, and participation in multilateral organizations. However, without more effective strategies and better policy implementation, the U.S. role in the next phase of global health governance will diminish under the pressures of competing priorities and shrinking financial resources. To provide leadership over the course of the next decade, the United States should take the following steps to improve global health governance:

- Craft a comprehensive global health strategy for the U.S. government;
- Focus on priority areas of global health governance, namely the International Health Regulations 2005 (IHR 2005), global tobacco control, the Millennium Development Goals, and strengthening national health systems in developing countries;
- Embed global health as a priority for the Group of 20 (G20) by creating demand for global health issues on its agenda;
- Strengthen health cooperation within regional organizations; and
- Integrate health inputs into debates about global governance problems outside the health realm, such as economic governance, trade, and climate change.

Global Health and Global Governance

DEFINITIONS AND CONCEPTS

“Global health governance” refers to the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and nonstate actors to deal with challenges to health that require cross-border collective action to address effectively. This definition’s relative simplicity should not obscure the breadth and complexity of this concept.

Leading definitions of “health” conceptualize it in broad terms. The World Health Organization (WHO) defines health as “the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”³ Making progress toward the mere absence of disease or infirmity is hard enough without pursuing the more comprehensive conception of health, and the range and diversity of health threats that require collective action touch virtually every policy area.

To complicate matters, each health threat intertwines with political, economic, social, and environmental factors that shape how it emerges and spreads. For example, whether a pathogen “jumps species” from animals to humans depends not only on the microbe but also on the social, economic, and ecological realities that facilitate the pathogen’s presence in animals and its transmission to humans. In taking these kinds of “social determinants of health” into account, public health solutions must address issues such as poverty, hunger, education, housing, gender relations, environmental factors, and security conditions.⁴ These determinants shape patterns of disease emergence and prevalence in populations. To improve social determinants of health requires policies that penetrate into political, economic, and social contexts, often down to the local, neighborhood, and household levels.

Thinking about health as more than the absence of disease implies a normative outlook. Many regard enjoyment of the highest attainable standard of health as a fundamental human right and as consistent with respect for human dignity and social justice. Consequently, eliminating health inequities—defined by WHO as “the unfair and avoidable differences in health status seen within and between countries”⁵—becomes a moral imperative.

Taken together, the challenges presented by health threats, social determinants of health, and the normative imperatives of human dignity and social justice make the current scale and content of global health governance breathtaking. At the same time, this expansive scope complicates effective cooperation. The collective action mechanisms available to states, intergovernmental organizations, and nonstate actors are not well suited to producing health-centric, coordinated governance across all necessary policy areas. As a result, holes, fissures, and shifting sands appear in contemporary global health governance.

HEALTH IN WORLD POLITICS—A HISTORICAL PERSPECTIVE

The scope of international health cooperation has expanded greatly since the mid-nineteenth century. When states started negotiations on health, the effort was limited to certain communicable diseases—plague, cholera, and yellow fever—that posed direct threats to populations and the spread of which governments associated with trade and travel. This health diplomacy sought to improve responses to transnational communicable disease events while reducing the burden national health measures, such as quarantine, imposed on trade and travel.

Collective action on other health threats also began in the latter half of the nineteenth century. These efforts included attempts to mitigate pollution in rivers and lakes bordered by two or more countries; to regulate trade in alcohol to countries, colonial possessions, or other areas where its consumption was perceived to have become harmful; and to protect the health of combatants during war, including obligations to treat wounded soldiers humanely and prohibitions on expanding bullets.⁶ At the turn of the twentieth century, states began to negotiate treaties to protect workers from occupational safety and health risks—an effort that became part of the mandate of the International Labor Organization (ILO) established after World War I.⁷

Thus, even before creation of the first permanent intergovernmental health organizations, states, merchants, humanitarian organizations, and workers' associations had begun to tackle health problems requiring collective action. These efforts encompassed communicable diseases—the international sanitary conferences and conventions—and noncommunicable health harms—diseases and injuries caused by pollutants, alcohol, weapons and methods of warfare, and unsafe working conditions. Diplomatic activity worked at the intersections between economic activity, trade, armed conflict, and the threat of disease-causing pathogens, pollutants, products, weapons, and dangerous occupational environments.

Despite their diversity, these early attempts to construct international health regimes shared three characteristics. First, each addressed a direct threat to health. Second, these threats often had cross-border features that reflected interdependence among states, requiring cooperation and collective action. Third, health-related challenges were not prominent in states' foreign policies because they did not have an impact on the fundamental concerns of statecraft: power, influence, security, and survival.

Global governance on health solidified and diversified after World War II. Health remained part of international law on communicable diseases, armed conflict, labor, trade, and the environment.⁸ New concepts and concerns appeared with the 1948 establishment of the World Health Organization (WHO) as the UN specialized agency for health. Unlike the more limited mandates of earlier international health organizations (such as the Office International de l'Hygiène Publique), WHO defined health broadly and defended the highest attainable standard of health as a fundamental human right.⁹ Although WHO continued activities begun before its creation, it also went in new directions, providing assistance to developing countries and formulating strategies to advance the right to health, such as the push for universal access to primary health care in the "Health for All by the Year 2000" initiative. Moving away from a treaty-based approach, WHO operated as a scientifically grounded, technically focused institution guided by a humanitarian ethic that viewed health as central to human dignity. Instead of binding rules of international law, it mainly developed "soft law" norms.¹⁰

WHO achieved important successes with this approach, particularly in fighting communicable diseases. Between 1966 and 1977, WHO oversaw smallpox eradication efforts in over fifty countries, eliminating a disease that caused two million deaths annually. WHO also contributed significantly to the conquering of yaws, combating onchocerciasis (river blindness), and administering global immunization programs against communicable diseases.¹¹ WHO's work gave the organization credibility and authority, especially in developing countries.

Despite WHO's emergence and achievements, global health concerns had a low political profile during the Cold War, being eclipsed by the geopolitical concerns of powerful states. As developed countries made strides in lowering their vulnerability to communicable diseases, they lost interest in promoting international regimes designed to address these diseases. Global health became associated with humanitarian assistance to poor countries, an area of foreign policy subordinate to security, political, and economic interests. Arguments that collective action on health could create positive "spillover" effects for nonhealth policy matters gained no traction in this period. In the Cold War context, health issues were not important, except when they touched upon conflicts between the West, the Soviet bloc, and developing countries.

Most notably, the WHO-led effort to advance universal access to primary health care through the Declaration of Alma-Ata in 1978 was controversial because it embraced the effort by developing countries in the United Nations, supported by the Soviet Union, to create a new international economic Order—an effort opposed by Western powers. The Alma-Ata declaration also suffered unfortunate timing, emerging only a year before the Islamic revolution in Iran, the second global oil crisis, and the Soviet invasion of Afghanistan. Against this backdrop of East-West wrangling, the WHO "Health for All" initiative did not register in the primary concerns of the great powers.

By the end of the Cold War, global health governance spanned a range of regimes developed through international health, trade, labor, humanitarian, human rights, and environmental law. WHO served as the center of this loosely connected system, acting as the primary locus for normative principles, institutional foundation for collective action, and scientifically based and technically oriented assistance. Nevertheless, global health governance operated as part of the "low politics" of foreign policy, and, thus, never gained prominence either in the interests of states or the workings of the international system.

THE REVOLUTION IN GLOBAL HEALTH GOVERNANCE

A revolution in global health governance has been underway during the past ten to fifteen years, with vigorous challenges to the legacy inherited from the Cold War. This revolution increased the number of formal and informal institutions engaged with global health, produced an explosion in the number and type of actors seeking to influence global health outcomes, generated new regimes and initiatives on global health problems, witnessed unprecedented increases in funding, and raised the profile of health in foreign policy. The revolution also raised the visibility of social determinants of health, while revealing the inadequacy of existing health governance in addressing them.

No longer a purely humanitarian objective, global health is now considered important for national and international security, domestic and global economic well-being, and economic and social development in less-developed countries. Pandemic influenza has become a threat to national and global security; epidemics of communicable diseases and some noncommunicable diseases create disruptive and expensive economic burdens; and the human and economic costs of HIV/AIDS, malaria, tuber-

culosis, and other problems undermine bilateral, regional, and multilateral development strategies. Thus, states afford health greater significance in formulating their interests, articulating and advancing them in diplomatic venues, and pursuing them through collective action.¹²

As a result, global health governance has become more political and less dominated by humanitarian-focused technical experts applying the tools of science, medicine, and epidemiology. In the foreign policies of major countries, health now features in “soft power” and “smart power” agendas, reflecting its status as a more prominent foreign policy challenge. According to Maria Otero, under secretary of state for democracy and global affairs, President Barack Obama has made his Global Health Initiative a core part of his “smart power”-driven foreign policy.¹³ In the field, U.S. aid agencies are placing greater emphasis on global health as part of both development and counterinsurgency strategies.¹⁴

Massive increases in development assistance for health (DAH) illustrate global health’s rise in importance. From 1990 to 2007, such DAH is estimated to have grown from \$5.6 billion to \$21.8 billion, nearly a four-fold increase in two decades.¹⁵ The most dramatic single change involves funding for HIV/AIDS, which went from \$0.2 billion in 1990 (3.4 percent of DAH) to \$5.1 billion in 2007 (23.3 percent of DAH). DAH for malaria, tuberculosis, and health sector support also grew over this period, even though each of these areas still constitutes a small proportion of overall DAH.¹⁶ Although concerns about the effectiveness of DAH remain, the global health community believes that DAH saves and improves lives.¹⁷

With increased attention to global health, the number of relevant actors has increased, complicating the role of WHO. Once the acknowledged center of gravity, WHO now faces competition from other IGOs, such as the World Bank and the World Trade Organization (WTO); informal but influential collective action mechanisms, such as the Group of 8 (G8); individual countries’ initiatives, especially the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR); multinational corporations (MNCs), particularly in the tobacco and pharmaceutical industries; and nongovernmental organizations (NGOs) and philanthropic foundations, especially the Bill and Melinda Gates Foundation.

In addition, leading countries and other actors have elected not to house new initiatives within WHO, such as the UN Joint Program on AIDS (UNAIDS), the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), the International Finance Facility for Immunization (IFFIm), and the Advance Market Commitments for Vaccines (AMCV). Between 1990 to 2007, “the proportion of assistance going to UN agencies and development banks has decreased . . . [and] [t]he role of NGOs . . . has expanded tremendously, as has direct bilateral assistance to governments in low-income and middle-income countries.”¹⁸ Some global health experts worry that the shift away from UN agencies, such as WHO and the UN Children’s Fund (UNICEF), means these agencies have “to compete with recipient countries, NGOs, and other organizations for available DAH funds,” which risks “undermining their crucial role as trusted neutral brokers between the scientific and technical communities on the one hand, and governments of developing countries on the other.”¹⁹

New and unprecedented institutional arrangements have arisen to address specific problems, especially HIV/AIDS, international public health emergencies, and the pandemic in tobacco-related diseases. The HIV/AIDS pandemic has produced a multifaceted regime that involves UNAIDS (created in 1996), the Global Fund (established in 2002), initiatives by the G8, significant donor funding for treatment, and extensive NGO involvement. The pandemic of tobacco-related diseases led WHO to adopt in 2003 the Framework Convention on Tobacco Control (FCTC), the first time

WHO adopted a treaty under Article 19 of the WHO constitution. The FCTC launched an unprecedented global anti-tobacco movement. Threats of naturally occurring or man-made communicable diseases (such as Severe Acute Respiratory Syndrome, or SARS, influenza, and bioterrorism), along with the threat of trans-boundary chemical and radiological accidents or intentional releases, produced the revised International Health Regulations in 2005. The IHR 2005, which connects global health to security, economic, development, and human dignity interests, constitutes one of the most radical governance innovations since health diplomacy began in the mid-nineteenth century (Figure 1).²⁰

States, IGOs, and nonstate actors also began to address wider aspects of global health governance. These efforts included acting on how health affects macroeconomics, economic development, and social determinants.²¹ In collaboration with governmental and nongovernmental partners, WHO focused more attention on noncommunicable diseases, a push manifested in not only the FCTC but also strategies on obesity-related diseases, road traffic injuries, and harmful uses of alcohol.²²

Global health governance also became more important in regimes designed to achieve non-health objectives. For example, “trade and health” controversies arose within the WTO, regional trade agreements, and bilateral trade accords, especially with respect to the effect of intellectual property rights on access to medicines.²³ These controversies, combined with problems created by HIV/AIDS and other outbreaks, raised global health’s profile within the human rights community and led to new attention on the right to health.²⁴ Global health capabilities, such as surveillance and response capacities, emerged as significant in efforts to prevent development and use of biological weapons through the Biological Weapons Convention.²⁵ Global health policymakers also provided inputs into governance reform initiatives on the global economic, food, energy, and climate change crises.²⁶

Finally, the eight Millennium Development Goals (MDGs) affirmed health as a focal point of global governance. Three of the MDGs target specific health objectives (HIV/AIDS, maternal health, and child health), and four others attempt to improve social determinants of health, namely poverty and hunger, education, gender equality, and environmental protection.²⁷ The WHO Commission on Social Determinants of Health reinforced the message of the MDGs and elevated efforts to improve such determinants on WHO’s agenda.²⁸

Figure 1. International Health Regulations 2005

The IHR 2005 represents a radical break from predecessor regimes in five respects:

1. *Expansive Scope:* The IHR 2005 contains an expanded scope of application that goes beyond anything seen in earlier regimes, which traditionally only applied to a small number of communicable diseases. The agreement applies to disease events regardless of nature or origin. Thus, the IHR 2005’s scope covers naturally occurring communicable diseases and accidental or intentional releases of biological, chemical, or radiological agents. The expanded scope affects many aspects of the IHR 2005, including the obligations to notify WHO of any disease event that may constitute a public health emergency of international concern.
2. *Minimum Core Obligations:* The IHR 2005 requires all states parties to develop and maintain minimum core surveillance and response capabilities. Nothing like these capacity-building obligations ever appeared in a past treaty on public health. The obligations recognize that, without such capabilities, efforts to prevent the spread of disease will be compromised.

3. *WHO Use of Nongovernmental Sources of Information:* The IHR 2005 authorizes WHO to use information it receives from nongovernmental sources. This approach breaks with previous rules that restricted WHO to using only government-provided information. This new authority strengthens WHO's early warning and surveillance activities, and such sources of information have become important in the IHR 2005 and the Global Outbreak and Alert Response Network (GOARN).
4. *WHO Power to Declare a Public Health Emergency of International Concern:* The IHR 2005 authorizes the WHO director-general to declare a public health emergency of international concern and, after doing so, to issue temporary recommendations on how states parties should respond to such an emergency. The WHO director-general can make such a declaration even over the objections of the states parties directly affected.
5. *Incorporation of Human Rights:* The IHR 2005 incorporates human rights into its provisions, which require states parties to respect an individual's dignity, human rights, and fundamental freedoms when applying disease control measures to travelers. Human rights had not featured in earlier versions of this regime.

In sum, the revolution in global health governance has had two fundamental impacts. First, it elevated the importance of health in many global governance regimes. Although health's appearance across regimes is not new, its elevated status has increased the importance of these regimes and the health-related scrutiny to which the regimes are subject. Second, the revolution in global health governance has brought into sharper focus the root causes of ill health and inequitable health outcomes. In doing so, it puts root-cause problems, such as the social determinants of health, squarely in the mix of debates about how global health governance functions. This focus has revealed the inadequacies of existing global governance approaches to these challenges.

The Global Health Governance Regime Complex

Given its massive scope and cross-cutting relevance to multiple policy areas, global health is not governed by a single regime but rather a “regime complex,” or “a collective of partially overlapping and nonhierarchical regimes.”²⁹ Regime complexes are not unique to global health, but the regime complex governing health may be one of the most complicated in world affairs. Indeed, the global health governance regime complex is actually composed of several overlapping “regime clusters” in which multiple players address specific problems through different processes by applying various principles.

The needs of public health explain to a large degree the presence of so many regime clusters. Effective health strategies must be specifically tailored to each situation, combining surveillance—the collection, analysis, and dissemination of epidemiological information—and interventions—measures to prevent, protect against, or respond to health threats. Solutions that work in one context often cannot be translated into another; consequently, global health governance needs different regimes purpose-built for specific challenges.

For example, although both are communicable diseases, the approach to HIV/AIDS should not guide preparations for pandemic influenza. Preventing occupational injuries mandates different techniques than reducing the demand for tobacco. Similarly, the regulation of the application of sanitary and phytosanitary measures to trade in goods is not a template for preventing trans-boundary pollution. And the process of developing a new antibiotic for drug-resistant tuberculosis does not reduce poverty in the developing world. Although public health experts seek multipurpose surveillance and intervention capabilities where possible, surveillance and response interventions do not often support actions against multiple problems.

Political interests help produce the multitude of regime clusters in global health. Consider the proliferation of efforts to address HIV/AIDS: activities began with the WHO Global Programme on AIDS, but have expanded to include UNAIDS, human rights bodies, the Security Council, the World Bank, WTO, the MDGs, the Global Fund, G8 initiatives, regional efforts, bilateral programs, and various NGOs. The HIV/AIDS regime cluster reflects how states, IGOs, and nonstate actors have framed HIV/AIDS as a security, economic, development, and humanitarian issue. It also reflects how powerful actors and influential processes, such as the United States and the G8, created new initiatives (such as PEPFAR and the Global Fund) to address specific concerns rather than strengthening efforts within UNAIDS and WHO.

GLOBAL HEALTH PLAYERS

The revolution in global health governance has increased the quantity and diversity of players (see Table 1). This development has intensified competition for leadership, influence, and resources. States, IGOs, and NGOs have long been involved in global health, but the participation of each type

of player has changed. In addition, public-private partnerships (PPPs) emerged as new actors. Global health governance has truly gone “multipolar,” with many more players more deeply engaged than ever before.

Donor states, especially the United States, have increased development assistance for health but have done so mainly through bilateral aid, such as the President’s Emergency Preparedness for AIDS Relief (PEPFAR), or new mechanisms, such as the Global Fund, which bypass traditional institutions, such as WHO or the World Bank.³⁰ These shifts reflect the growing importance of global health to powerful states, which are exerting greater control over resources they expend in this area. Established and emerging powers, such as the United States, China, and Brazil, increasingly view global health as a component of “soft” or “smart” power.³¹ This heightened interest by major countries has elevated global health politically, but it also reveals how the divergent interests of states shape global health.³²

Table 1.

Player category	Examples	
States	Great powers	United States, China
	Emerging powers	India, Brazil
	Developed states	Britain, Canada, Germany, Japan, Norway
	Developing countries	Bangladesh, Indonesia, Kenya, Venezuela
	Failing or failed states	Congo, Haiti, Zimbabwe, Somalia
IGOs	Multilateral	ILO, UN, UNAIDS, UNICEF, World Bank, WHO, WTO
	Regional	African Union, ASEAN, European Union
PPPs	Mechanisms to increase access to health technologies	AMCV; GAVI Alliance; Global Fund; IFFIm
	Drug and vaccine development partnerships	Drugs for Neglected Diseases Initiative, International AIDS Vaccine Initiative, Medicines for Malaria Venture, Malaria Vaccine Initiative, TB Alliance
Nonstate actors	Philanthropic foundations	Bloomberg Initiative, Carter Center, Clinton Foundation, Gates Foundation, Rockefeller Foundation
	NGOs and civil society groups	Amnesty International, Doctors Without Borders, Human Rights Watch, Oxfam
	Multinational corporations	Food and beverage, pharmaceutical, and tobacco companies

IGOs remain central actors, but the revolution in global health governance has affected them in complex ways. On the one hand, IGOs have become more prominent as venues for analyzing problems, designing solutions, and facilitating negotiations. In this regard, WHO has never been more

important. Similarly, multilateral institutions, such as the World Bank and WTO, and regional organizations have also gained significance. On the other hand, the growth in bilateral initiatives, development of alternative diplomatic processes, and expanded influence of nonstate actors have made the environment for IGOs more complicated, competitive, and difficult. These changes have challenged WHO's legacy as the central institution in global health and forced it to adapt in the face of declining influence.

Nonstate actors have been important since health cooperation began, as illustrated by the pressure merchants put on governments to address national quarantine systems in the second half of the nineteenth century, the involvement of workers' associations in the development of international labor standards before and after World War I, and the public health achievements of the Rockefeller Foundation in the first decades of the twentieth century. But nonstate actors now enjoy more influence on global health than ever before. The globalization of trade, commerce, and finance has expanded the impact of certain private enterprise sectors, including the pharmaceutical, tobacco, and food and beverage industries. MNCs now play a significant role in diplomacy on intellectual property, labor and product safety standards, and trade in tobacco, alcohol, and food and beverage products. In many cases, the WTO has bridged the gap between trade and health.³³

The not-for-profit sector also has a higher profile now than in any other previous period. The impact of NGOs has increased partly because of their expanded use by states and multinational corporations as direct recipients of aid and in-kind contributions, such as donated medicines.³⁴ Philanthropies have also helped transform global health, most notably through the efforts of the Carter Center, the Clinton Foundation, and the Gates Foundation.³⁵ The Gates Foundation, in particular, has been a "game changer" because of the unprecedented resources it devotes to global health. Since its creation in 1999, the Gates Foundation has disbursed nearly \$10 billion in global health grants.³⁶ The scale of the foundation's resources has "resulted in almost every university department, think tank, civil society group and partnership working in this area, receiving funding from it directly or indirectly."³⁷ After the United States and the United Kingdom, the Gates Foundation "is the third largest contributor to the WHO," and it participates in leading PPPs, including the Global Fund, the Global Alliance for Vaccines and Immunization (GAVI Alliance), the Malaria Vaccine Initiative, and AMCV.

These and other PPPs are new players that have had widespread impact, especially in terms of resource availability for global health. Two of the biggest PPPs created in the past decade, the Global Fund and GAVI Alliance, "have attracted a growing share of funds, while the proportion of assistance going to UN agencies and development banks has decreased during this period."³⁸ Other PPPs, such as the IFFIm, UNITAID, and AMCV, have raised new funds through innovative financing mechanisms. PPPs have also been active in developing new medicines and vaccines for HIV/AIDS, malaria, tuberculosis, and neglected communicable diseases.

GLOBAL HEALTH PROBLEMS

The number and variety of global health problems on foreign policy agendas has also increased and continues to expand. Beyond traditional concerns with direct trans-boundary threats (for example, communicable diseases and cross-border pollution), the challenges now encompass additional communicable and noncommunicable health harms, health infrastructure problems (such as water and sanitation, surveillance and response capacities, health care systems), and deteriorating social determinants of health (Table 2).

The diversity of problems creates two main difficulties for global health governance. First, global health problems do not all generate the same level of interest from states. In terms of foreign policy, states tend to be more interested in problems that directly threaten their interests, require collective action in order to minimize the threat, and involve limited, feasible interventions. This pattern can be seen in the attention states have given to direct, cross-border transmission of dangerous communicable diseases. However, many problems do not involve such transmission (noncommunicable diseases related to tobacco consumption, for example) and require more complicated, expensive, and open-ended solutions (such as reducing poverty, hunger, gender discrimination, and environmental degradation in poor countries).

Second, the expanding agenda creates pressure to prioritize responses because of scarce political and economic capital and public health capabilities. Complaints about communicable diseases, generally, and HIV/AIDS, specifically, getting a disproportionate share of attention and resources reveal disagreements about how priorities are established.³⁹ Calls for more evidence-based priority setting are admirable but often do not reflect the way states, especially powerful ones, decide when, how, and why they get involved in collective action for global health. This prioritization dilemma means that the quantity and quality of global health governance is uneven.

Table 2.

Problem	Examples	
Disease-specific problems	Communicable diseases	HIV/AIDS, influenza, SARS, malaria
	Noncommunicable diseases	From environmental pollution, tobacco consumption, alcohol abuse, or obesity
	Injuries	From occupational settings or road traffic accidents
Threat-specific problems	Trans-boundary pollution; biological, chemical, or radiological terrorism	
Insufficient resources	Lack of funds for tobacco control programs mandated in the FCTC and for minimum core surveillance and response capacities required in the IHR 2005	
Social determinants of health	Poverty, hunger, poor education, gender discrimination, environmental degradation	
Coordination of development assistance for health	Too many donors working on HIV/AIDS programs, donor priorities prevailing over recipient government preferences	
Health system problems	Health system capacity building, shortage of health workers, poor national governance, corruption	

GLOBAL HEALTH PROCESSES

As players and problems have increased, the number and diversity of diplomatic processes addressing global health have expanded (see Table 3). The proliferation of health issues on diplomatic agendas has occurred at multilateral, regional, and bilateral levels. The multiplication of processes has contributed to a governance patchwork that many experts perceive as fragmented, inefficient, and incapable of producing a convergence of interests, strategies, and resources, which often makes it difficult

for developing countries to participate effectively. The multiplication of processes also affects WHO because it is frequently invited to participate or is affected by outcomes reached.

Table 3.

Type of Process	Examples
Multilateral	World Health Assembly
Bilateral	PEPFAR
Status-based	G8, G20
Regional	APEC, ASEAN, European Union
Identity-based	Organization of the Islamic Conference
Resource-generating	Global Fund, IFFIm, UNITAID
Functional	Health 8, GAVI Alliance, International Health Partnership +

The number of diplomatic processes is not spread evenly over global health. Some problems, such as HIV/AIDS, have multiple, overlapping, and well-funded governance processes. Other concerns, such as obesity, road-traffic injuries, and mental health, are addressed in fewer forums that generate less political interest and fewer financial resources. The number of processes in a regime cluster is not, however, necessarily an indicator of that cluster's effectiveness, as evidenced by the failure of global governance on HIV/AIDS prevention.

The proliferation of processes also stimulates competition among the players. For example, in "regime shifting," one actor attempts to move a problem to a diplomatic process more conducive to its interests. This phenomenon appeared in the tussle pitting protection of intellectual property against the campaign for access to essential medicines.⁴⁰ Global health and human rights groups tried to shift the debate into WHO and UN human rights bodies and away from the WTO, but champions of intellectual property rights for pharmaceuticals reshifted the forum to bilateral and regional trade agreements.

GLOBAL HEALTH PRINCIPLES

The quantity and variety of principles guiding global health has also increased during the revolution in global health governance. Many of the new binding rules come from two treaties WHO crafted during this period: the International Health Regulations in 2005 and the Framework Convention on Tobacco Control in 2003. In terms of nonbinding norms, the Millennium Development Goals and the Global Fund stand out as breakthroughs.

Although adoption of the IHR 2005 and the FCTC might suggest that the players are becoming more interested in binding international law for global health, this perspective ignores the long-standing binding rules of international law relevant to public health. In addition, most recent innovations in global health governance are nonbinding. For example, the following are all nonbinding mechanisms, objectives, commitments, or strategies not based in international legal instruments:

- Global Fund;
- Millennium Development Goals;
- G8 pledges of development assistance for health;

- Innovative financing mechanisms (such as IFFIm, UNITAID, AMCV);
- Coordination processes (for example, International Health Partnership +, Health 8);
- Promises to respect recipient country preferences and plans for development assistance; and
- Adopted or proposed strategies concerning diet and nutrition, harmful use of alcohol, marketing food and nonalcoholic beverages to children, and recruitment of health workers.

Existing norms have also undergone more scrutiny and, in some cases, have been refined to clarify how health and other interests get balanced. Refinement of the right to health has occurred through an interpretation by the UN human rights process, and in the relationship between trade and health through case law decided by the WTO's Dispute Settlement Body.⁴¹ The rising importance of health in development thinking has also contributed to principles that stress ownership of development assistance for health and alignment of aid with recipient country objectives.⁴²

COORDINATION AND COHERENCE

Changes in players, problems, processes, and principles have made long-standing regime clusters, such as international trade, more complicated and controversial. In addition, these changes have generated new or transformed regime clusters, which address expanding threats, such as tobacco, and functional challenges, such as delivery of vaccines for childhood diseases. By one estimate, global health is addressed by “more than 40 bilateral donors, 26 UN agencies, 20 global and regional funds, and 19 global-health initiatives.”⁴³ Overlaps, linkages, redundancies, and conflicts between regime clusters have heightened the need for coordination within the global health governance regime complex.⁴⁴ Development of mechanisms, such as the International Health Partnership + for health assistance coordination, the “Health 8” initiative to coordinate actions on achieving the Millennium Development Goals, and the UN System Influenza Coordination process, illustrate the demand for better collaboration.⁴⁵

The need for more and better policy coordination and coherence echoes similar calls made within national governments for interagency collaboration and “whole-of-government” strategies. However, coordination and coherence within global health are larger tasks, given the ubiquity of health issues across policy areas. Better, more effective coordination and coherence in global health represents a “whole-of-globalization” challenge. The scope and complexity of this challenge often outstrips the ability of states, IGOs, and nonstate actors to engage in effective collective action across the entire global health governance regime complex.

Content and the Quest for New “Architecture” in Global Health Governance

Although preferable to the neglect experienced in the past, the revolution has inspired calls for reforms and a new “architecture” of global health governance. Originally, the “revolution” occurred reactively in response to a parade of global health problems that countries and the international community allowed to emerge. A tenet of public health is prevention of health threats. Yet, global health governance responses to HIV/AIDS, SARS, avian influenza, H1N1, malaria, tuberculosis, tobacco-related diseases, obesity-related diseases, antimicrobial resistance, and health-threatening counterfeit drugs have mainly, if not entirely, come after these threats became global dangers.

Global health governance has consistently fallen short of achieving the culture of prevention necessary to its long-term success. This failure has been particularly acute in the HIV/AIDS pandemic because responses have focused predominantly on treatment, leading experts to make dire predictions about the sustainability of current policy.⁴⁶ These concerns help explain why UNAIDS plans to launch a “prevention revolution” in 2010.⁴⁷ Prevention failures appear in other contexts as well, including standards for occupational safety and health. The ILO has promulgated more than forty standards, forty codes of practice, over twenty treaties, and a global strategy for occupational safety and health—with little success.⁴⁸ In 1999, the ILO estimated that occupational accidents produced as many as 250 million injured workers and 160 million cases of occupational diseases annually; ten years later, the ILO reported: “Every year more than 2 million people die from occupational accidents or work-related diseases. By conservative estimates, there are 270 million occupational accidents and 160 million cases of occupational disease.”⁴⁹

Prevention aside, the effectiveness of new responses to global health threats has been questioned. The explosion of actors, institutions, initiatives, and funding has created an environment characterized by political competition, regime fragmentation, lack of evidence-based priority setting, wasted money, and policy and normative incoherence. Specific innovations also face questions about their effectiveness and sustainability. Although experts hail the FCTC’s adoption, tobacco consumption continues to grow, especially in developing countries, while FCTC implementation shows signs of losing momentum. In 2009, WHO reported:

- Less than 10 percent of the world’s population is covered by any of WHO’s recommended measures to reduce demand for tobacco.
- “Progress on implementing bans on tobacco advertising, promotion and sponsorship has stalled, leaving more than 90 percent of the world’s population without protection from tobacco industry marketing.”
- “Progress on increasing tobacco taxes has also come to a halt, with nearly 95 percent of the world’s population living in countries where taxes represent less than 75 percent of retail price.”

- “Tobacco control remains severely underfunded, with 173 times as many dollars collected worldwide through tobacco tax revenues each year than are spent on tobacco control.”⁵⁰

Similarly, although the IHR 2005 proved its utility during the outbreak of H1N1, many states parties will not be able to comply with the regulations’ requirements for developing core surveillance and response capacities by the 2012 deadline. The lack of a strategy with committed funding to help developing countries meet these obligations frustrates these nations and might undermine the regime’s legitimacy if not addressed.

The innovations in the IHR 2005 have also proved unhelpful to problems that have emerged with avian influenza and H1N1, especially the lack of equitable vaccines.⁵¹ The IHR 2005 is not designed to produce equitable access to vaccines or drugs; thus, the regulations have not been relevant to the efforts, so far unsuccessful, to negotiate a new regime for equitable access. The challenge of equitable access to vaccines for H1N1 was called one of the most important issues of our times, but efforts to meet this challenge were disappointing. Only the mildness of the pandemic strain kept this failure from wreaking more political damage.

A broader perspective yields more discomfort. Despite discernable progress, fulfillment of the Millennium Development Goals is lagging for many reasons, including the impact of the global economic crisis.⁵² Efforts to strengthen health advocacy in negotiations on the economic crisis, food security crisis, and climate change have also borne little, if any, fruit. As global health expert Laurie A. Garrett observed in connection with climate change:

[D]espite a vigorous campaign to raise health concerns in advance of the [Copenhagen] summit, human disease and traumatic injury threats appear to have played no significant role in the debates, and there are only passing, insignificant references to them in the final, dismal document. . . . It is impossible to imagine any ecological shift likely over the next fifty years that will more dramatically impact human health. Yet the “health community” failed politically in Copenhagen.⁵³

The problems with global health governance have stimulated calls for reforms. Proposals tend to fall into three categories. The first category contains proposals that would replicate existing strategies for problems not adequately addressed, for example, by applying an FCTC-like approach to threats posed by alcohol abuse and obesity.⁵⁴ The second category would draft new treaties for other problems, such as a convention on medical research and development.⁵⁵ The third would tinker with existing machinery, for example by adding a “Committee C” to the World Health Assembly to provide input from NGOs.⁵⁶

Bolder plans to craft a new architecture for global health governance tend to lack specifics that would give these concepts concrete form.⁵⁷ A proposal that illustrates this tendency is one that advocates for a multilevel, multipurpose, and multistakeholder partnership coordinated by a WHO and implemented by “global action networks.”⁵⁸

The perceived inadequate progress on social determinants of health has stimulated a proposal for a framework convention on global health that would help the world’s most vulnerable people have their “basic survival needs” met.⁵⁹ However, this proposal provides few details about what binding obligations this convention could actually contain. WHO representatives have likewise argued that a new “global framework” to achieve equitable access to influenza vaccines should be created before

the next pandemic in order to avoid the problems experienced with avian influenza and H1N1.⁶⁰ What this global framework should include or how it would function remains unclear.

Perhaps more problematically, broader reform proposals tend not to provide a convincing rationale as to why states would pursue these changes, particularly in light of political and economic circumstances in the near future. Many reform schemes assume continuation of the momentum global health experienced since the end of the Cold War, but global health faces a more difficult environment in the coming years and that momentum may likely wane.

After the Revolution: Looming Challenges for Global Health Governance

The periods following most revolutions involve uncertainty, and the current phase in global health governance is no exception. Further expansion and radical change are less likely in the next decade than either consolidation of recent changes or the decline of global health in international political importance.

The prospects for new, overarching reforms to global health architecture are negligible for five reasons. First, the broad and diverse governance challenges presented by global health make a single, unified architecture unrealistic. There are few policy realms that do not have direct or indirect impact on health. As the Obama administration's Global Health Initiative (GHI) put it, "The needs are too vast and the challenges too great for any one country or organization to address alone."⁶¹ Attempting to coordinate all the collective action necessary to deal with health's broad policy relevance is not practical; global health problems present different governance challenges. How states, IGOs, and nonstate actors deal with influenza differs epidemiologically from how malaria, bioterrorism, tobacco, and environmental pollution must be addressed. Health's broad and diverse nature as a policy arena produces a complicated regime complex and precludes creating rationalized, centralized, and harmonized architecture for global health governance.

Second, global health's increased political importance in security, economic, development, and humanitarian contexts makes powerful states and influential nonstate actors less willing to restrict their freedom of action. Domestic fiscal pressures on the United States are unlikely to increase the U.S. government's willingness to reduce its control of funds allocated for global health. The Gates Foundation will not allow WHO or any other intergovernmental process to determine how it spends resources for global health. Thus, global health will continue to experience multiple actors, initiatives, processes, strategies, funding streams, and regime clusters, which will create coordination challenges and complicate efforts to produce coherence.

Third, global health will also increasingly operate within the multipolarity emerging in international politics.⁶² Multipolarity does not mean the death of global health governance. Emerging powers appear as committed to chief global health governance innovations, such as the IHR 2005, as the United States, making them unlikely to become revisionist global health spoilers. Nevertheless, multipolarity will heighten the obstacles to achieving significant governance reforms in global health. As witnessed in negotiations within the WTO, G20, and the Copenhagen Climate Change Conference, emerging powers, especially China and India, are negotiating hard to have their interests reflected. The stalemate within the WTO Doha Development Round and the controversies over the Copenhagen accord reveal how difficult it can be to bridge divides between established and rising powers. Similar problems might emerge within the G20, and it is an important question whether the G20 can or will act on global health as the G8 did.

Fourth, the revolution in global health governance has been eclipsed by crises—including the global economic, energy, food insecurity, and climate change crises—and the economic and political damage these crises have caused. The major powers are unlikely to make overhauling global health governance a political priority in the midst of dealing with such on-going challenges. Other problems have also marginalized global health, such as the conflicts in Afghanistan and Pakistan, concerns about Iranian nuclear proliferation, and heightened fears about global terrorism.

Fifth, the eclipse of global health governance by other crises and problems underscores that, in the coming decade, significant decisions affecting health will take place outside the global health sector and might be made in ways that do not reflect the input of health policymakers. Thus, how the G20 manages global economic governance in the aftermath of the global economic crisis, whether the WTO concludes the Doha Development Round, what progress countries make on climate change, and how the emergence of new great powers affects security arrangements will shape the context in which global health governance evolves.

In short, the next decade will make the last one look like a golden age in global health governance. However, during its revolutionary period, global health governance crossed a Rubicon: health concerns, interests, and commitments became sufficiently embedded in foreign policy endeavors that global health is unlikely to return to the outer margins of “low politics” in world affairs. This reality holds at the multilateral level, whether the issue is trade liberalization or proliferation of biological weapons. The level of activity in regional organizations has also increased, and regional cooperation might offer a promising area for global health actions.⁶³ Influential countries that fueled the political rise of global health will continue to adapt their strategies, and emerging powers, such as China and Brazil, will take global health more seriously than rising great powers did in previous eras.⁶⁴

U.S. Leadership and Global Health Governance Over the Next Decade

The United States enters the next decade without the political and economic predominance it enjoyed earlier this century and in the last decade of the twentieth century. Indeed, its ability to fulfill existing commitments, particularly its financial contributions on HIV/AIDS, has come into question as the U.S. fiscal position deteriorates. In April 2010, the *Boston Globe* reported that “U.S. officials have asked some AIDS clinics overseas to stop enrolling new patients in a U.S.-sponsored program that provides lifesaving antiretroviral drugs, in a bid to stem the rising costs of one of the most ambitious U.S. assistance programs”⁶⁵ Such moves have cast a pall over global HIV/AIDS efforts because they limit treatment at a time when significant numbers of new infections continue to occur.⁶⁶

The dire fiscal outlook, exacerbated by the increasing short-term costs of the conflict in Afghanistan, new medium-term U.S. pledges of foreign aid for climate change, and the unknown but potentially massive long-term costs of domestic health care reform, challenges the U.S. ability to support global health financially at increasing or perhaps even at existing levels.⁶⁷ Doubts exist that the Obama administration can get Congress to fully fund its proposed five-year, \$63 billion Global Health Initiative. A sign of potential difficulties ahead came in late April 2010, when the U.S. Senate Budget Committee proposed cutting \$4 billion of nonsecurity discretionary spending from the Obama administration’s FY 2011 foreign assistance budget request—a cut that would affect development programs, including those involving health.⁶⁸

Beyond aid, the Obama administration faced criticism in connection with its pledge to donate vaccine for H1N1 to WHO for use in developing countries. In September 2009, the administration promised, with other developed countries, to donate 10 percent of its vaccine supply.⁶⁹ Less than two months later, it had to postpone fulfilling its pledge when the United States experienced problems meeting domestic demand.⁷⁰ This decision undercut the rhetorical U.S. commitment to equitable access to influenza vaccines and revealed the inadequacy of existing mechanisms to provide such access.

The Obama administration’s efforts to integrate U.S. global health interests within a new vision for foreign assistance reveal the difficulties of producing policy coherence within the U.S. government. The administration’s GHI is designed to be informed by a comprehensive strategy for U.S. foreign assistance, but the final GHI strategy and the larger framework for coordinated U.S. foreign assistance has yet to appear in full. GHI proposals have been criticized for an alleged reduction in financial support for HIV/AIDS and a lack of adequate funding across the initiative.⁷¹ Whether or not this criticism is warranted, it underscores the constraints that fiscal imperatives place on U.S. global health policy and the difficulty of recalibrating priorities and reallocating resources.

Little in the GHI strategy indicates that the Obama administration wants to reform global health governance. Although a key GHI principle is “to strengthen and leverage key multilateral organiza-

tions, global health partnerships, and private sector efforts,” the GHI simply proposes working more effectively with existing mechanisms, such as the UN, GAVI Alliance, and Global Fund.⁷² Nor did a leaked copy of a draft National Security Council Presidential Study Directive (PSD-7) on “A New Way Forward on Global Development” shed more light on this issue, stating that the “United States will redouble its efforts to support, reform, and modernize multilateral development organizations most critical to our interests.”⁷³

Given the controversies experienced in crafting GHI as part of a broader whole-of-government strategy for foreign assistance, implementation of GHI and the overarching aid strategy will encounter problems on the path to domestic policy coherence. Whether those implementation issues adversely affect U.S. participation in global health remains to be seen. The Obama administration’s struggle to reform U.S. global health programs and foreign assistance thinking provide a glimpse of what attempting policy coherence on health globally would involve.

As the United States struggles to redefine its role in global health, no other donor countries are stepping forward to fill the leadership vacuum. Neither the European Union (which is still recovering from the global economic crisis and is newly reeling from the Greek debt debacle) nor Japan (which decreased its development assistance by 10.7 percent in 2009) seems prepared to pick up the slack generated by deterioration of the U.S. fiscal condition.⁷⁴ In addition, the G8 countries are falling behind in fulfilling existing commitments, such as the additional \$25 billion promised for Africa at the 2005 Gleneagles summit.⁷⁵

Emerging powers—particularly China, India, and Brazil—appear similarly unwilling to step in and address the problems the U.S. fiscal predicament potentially creates for global health. Although these emerging powers provide health-related assistance to other countries, all three remain recipients of health assistance, making them unlikely to expand their health aid significantly. Given the size of their populations, China’s and India’s best contribution to global health would be to improve health domestically. The scale of the problems both countries face in this regard will take significant political and economic capital, leaving little capacity for Chinese and Indian leadership on global health. Thus, global health governance’s next phase will not be fueled by the increases in financial contributions from the United States or other countries seen over the past decade.

POLICY OPTIONS

Although global health governance faces a more difficult context in the next decade than it did in the recent past, options exist for improving how the regime complex operates and how states, IGOs, and nonstate actors contribute to such improvements.

Formulating National Global Health Strategies

The importance of global health, combined with the complexity of global health policy and governance, requires countries to formulate integrated, coherent global health strategies. Both Switzerland and the United Kingdom developed such strategies and found them useful in forging interagency coordination and achieving coherent policy approaches.⁷⁶ The UN secretary-general has encouraged other UN member states to adopt similar integrated national approaches to global health.⁷⁷

The United States should formulate a comprehensive, government-wide global health strategy that ensures unity of purpose and effort across the complex range of global health issues in which the

United States has interests. The United States routinely develops comprehensive strategies in many areas, as illustrated by the Obama administration's National Strategy for Countering Biological Threats and the National Health Security Strategy.⁷⁸ Just as in the attempts to integrate diplomacy, development, and defense in counterinsurgency and stability operations, a whole-of-government strategy should guide the use of all elements of U.S. national power in global health.⁷⁹

A comprehensive U.S. global health strategy would go beyond the Obama administration's GHI because the GHI does not address many aspects of U.S. involvement in global health. For example, the GHI does not include guidance for U.S. efforts on implementing IHR 2005, pandemic influenza preparedness, U.S. health assistance to disaster-stricken countries, and noncommunicable disease problems. A U.S. global health strategy should also contain guidance on how the United States will approach perceived problems with global health governance.

A mandate from Congress for the Executive Branch to produce a global health strategy (as was done for the national health security strategy) would provide a stronger foundation for development of the strategy. Given its role in interagency collaboration and interfacing with IGOs, the Office of Global Health Affairs in the Department of Health and Human Services (DHHS) could lead the effort to produce a U.S. global health strategy, guided by the White House, National Security Council, and the secretary of health and human services.

Shoring Up Cornerstones of Global Health Governance

Although producing a single architecture to govern global health is not feasible, parts of the global health governance regime complex need priority attention. Critical steps include progress on implementing the IHR 2005, strengthening the FCTC, integrating serious prevention strategies into HIV/AIDS efforts, and re-calibrating global approaches to achieving the Millennium Development Goals. The goal of strengthening national health systems in developing countries must inform each step.

The IHR 2005 and the FCTC are breakthroughs, the failure of which would be damaging to global health governance and WHO. Both these treaties have provided glimpses of their potential, but both also face implementation problems that could, in time, neuter their promise and render them ineffective instruments.

Effective implementation of the IHR 2005 would contribute to advancing U.S. security, economic, development, and humanitarian interests. U.S. backing of the IHR 2005 must be of equal significance as the policies in the GHI. The United States must redouble its support for the IHR 2005, especially in helping developing countries meet their minimum core surveillance and response obligations. The lead agencies of this effort should be the Department of State and the Office of Global Health Affairs in the Department of Health and Human Services, supported by the Centers for Disease Control and Prevention.

The United States has not ratified the FCTC. Although some experts have urged FCTC ratification, the United States does not have to do so in order to help WHO, other countries, and nonstate actors fulfill that treaty's potential. Moving in this direction requires that the U.S. government acknowledge tobacco as a global health problem in which it should be more involved. The United States can strengthen in-country efforts by tasking the CDC to help WHO scale up technical assistance for tobacco control in developing countries, to support NGOs, and to partner directly with the global anti-tobacco efforts of the Gates Foundation and the Bloomberg Initiative.⁸⁰

Without progress on HIV/AIDS prevention, the massive effort waged since the 1980s will not gain sufficient traction to bring this crisis under control. Like most other participants in the HIV/AIDS fight, the United States has focused largely on treatment, and it has had trouble, especially in its own policy formulation, being a leader and remaining consistent on HIV/AIDS prevention. The Global Health Initiative intends to strengthen HIV prevention efforts by having PEPFAR “support the prevention of more than 12 million new HIV infections,” but the United States should do more.⁸¹ HIV prevention should be a central objective of both the GHI and the comprehensive strategy for foreign assistance. Through PEPFAR, the United States can be at the forefront of the “prevention revolution” by having its policies reflect the importance of prevention for long-term U.S. interests in reducing the burden of HIV/AIDS. This approach will require supporting evidence-based prevention strategies and allocating more resources to prevention activities.

Despite progress, many MDG targets appear unachievable, especially after the impact of the global economic crisis. Given that seven of the eight MDGs relate to health problems or social determinants of health, the inability to meet the MDGs by the 2015 deadline is disappointing for, but not fatal to, the enterprise. Most actors in global health support the MDGs, including the United States. The GHI states the “U.S. government will join multilateral efforts involving the United Nations and others to make progress toward achieving MDG goals four, five and six.”⁸² However, the time has come to rethink the MDGs as part of developing the next phase for this project, what some have dubbed “MDGs 2.0.” The Obama administration is missing an opportunity to lead on this issue by not advancing new thinking on the MDGs in the GHI or its larger foreign assistance vision. The U.S. Agency for International Development could lead a “lessons learned” process to assess what worked and what did not and to evaluate how the MDG process could be improved before as well as after the 2015 deadline.

One objective should cut across these four strategies: strengthening national health systems in developing countries. The need for such strengthening has long been recognized. The GHI seeks to “build sustainability through health systems strengthening,” and the leaked draft of PSD-7 wants the United States to invest in “building sustainable health systems.”⁸³ But improvements in this area are difficult to generate for many reasons, including the dominance of “vertical” assistance programs, the complexity of the endeavor, and how health systems are intermixed with other governance, political, and economic problems. Progress on the four issues described above will, however, contribute to building and maintaining sustainable health systems.

Tackling Persistent Problems in Key Regime Clusters

Beyond the cornerstones of global health governance identified above, global health actors could usefully target some persistent problems in key regime clusters—particularly intellectual property and influenza vaccine access. The continuing controversy on intellectual property has failed to reach any resolution, and new developments, such as the proposed Anti-Counterfeiting Trade Agreement, simply agitate the on-going friction in this area.⁸⁴ The United States is at the center of this storm, and White House leadership is essential to finding a solution. Presently, although the GHI stresses innovation, it does not directly address the global intellectual property controversy.⁸⁵ The leaked draft of PSD-7 highlights the importance of “game changing” technologies, such as vaccines for neglected diseases, weather-resistant seeds, and green energy technology, but it only enigmatically states that the U.S. government will work “with developing countries to increase their utilization of science and

technology and to remove impediments to innovation and adaptation by the private sector.”⁸⁶

The intellectual property controversy connects to another persistent problem—equitable access to influenza vaccines—that still requires serious global governance action. The lack of progress in the WHO-sponsored negotiations on this issue became evident again at the January 2010 WHO Executive Board meeting. In addition to intellectual property issues, this challenge includes increasing aggregate world influenza vaccine production capacities and making these capacities less geographically concentrated than they are now. Again, without the committed participation of the United States, this persistent problem will fester until the next influenza crisis.

Embedding Global Health in the Agenda of the G20

Global economic governance has undergone a shift with the G8 ceding prominence to the G20. How the simultaneous functioning of the G8 and G20 will affect global health governance is not clear. The G8 will remain active in global health given existing commitments, as suggested by the new initiative on maternal health proposed for the June 2010 G8 summit in Canada.⁸⁷ However, given the G20’s importance, the United States should ensure that the G20 addresses global health directly.⁸⁸ Moving in this direction would support the Obama administration’s objectives in the GHI and its vision for foreign assistance. Through the interagency process that handles U.S. participation in the G20, the United States can influence development of the G20’s comparative advantage as an effective high-level forum for collaboration and coordination on key global health objectives. The United States could propose creation of a system of “global health sherpas” through a division of labor among G20 members on global health challenges.

Strengthening Regional Cooperation on Health

Although much attention is paid to multilateral efforts on global health, the past ten to fifteen years have seen health cooperation become more important in regional organizations.⁸⁹ For example, the African Union, Association of Southeast Asian Nations, and European Union have scaled up their efforts on health. The African Union, in particular, has been “involved with activities designed to tackle HIV/AIDS, tuberculosis, malaria, and polio in Africa; health financing challenges in Africa; food security and nutrition; and the African Diaspora Health Initiative, which is designed ‘to link specific healthcare expertise within the African Diaspora with specific health needs in specific geographical locations in Africa.’”⁹⁰

The next stage of global health governance should draw on the strengths of regional organizations to consolidate gains generated by global health initiatives, address regional problems, and make health a “whole-of-region” objective. Through the Department of State, Department of Health and Human Services, and Centers for Disease Control and Prevention, the United States can advance this strategy through participation in and relations with regional organizations and processes around the world, particularly by assisting regional institutions with capacity building.

Providing Health Input on Other Global Governance Problems

Attempts to raise health issues in other global governance forums are not always successful, as illustrated by the lack of attention the Copenhagen Climate Change Conference paid to health.

However, the need to continue to “speak health to power” is important, particularly because decisions in non-health issue areas will have a significant impact on health. These contexts include, but are not limited to, the global economic crisis, trade, climate change, food security, and energy policy.

The United States can help this effort by including health in its approach to global governance questions that arise in security, political, economic, and environmental contexts. Achieving this goal requires a strategic understanding of health in all areas of global governance, which underscores the importance of a global health strategy. The Obama administration’s proposal to elevate development to the same level as defense and diplomacy would be a first step to facilitate integrating health into U.S. policies.⁹¹

Conclusion

With the revolution over, the international community must shift its focus to producing resilience in global health governance. Global health will not see large-scale radical reforms, innovations, and funding increases in the next ten years. Instead, for actors in global health, the challenges will be to consolidate gains, make iterative improvements, and prepare for the health impacts that reforms in other governance realms might produce. U.S. leadership will remain critical, but the United States now faces more domestic and global difficulties than it experienced in global health since the end of the Cold War.

The agenda proposed here is not as dramatic as the breakthroughs that transformed the legacy institutions, strategies, and attitudes on global health over the past ten to fifteen years. However, revolutionary moments end, leaving the hard work of ensuring that the vision behind the revolution informs policy, influences practice, and achieves progress. Although faced with problems—many of which are beyond its influence—the global health community stands better positioned in the political, diplomatic, and governance spaces where states, IGOs, and nonstate actors shape globalization. This time, this community will not have the excuse that its neglect and marginalization leave it unprepared to try to influence world affairs.

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About the Author

David P. Fidler, a leading expert on international law and global health, is James Louis Calamaras professor of law at Indiana University School of Law.