



GLOBAL HEALTH CENTRE WORKING PAPER NO. 13 | 2016

NEW DIRECTIONS IN GOVERNING THE GLOBAL HEALTH DOMAIN - LEADERSHIP CHALLENGES FOR WHO

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Executive Summary

At present there is a very active and public debate on global health governance. The World Health Organization has made the process of the selection of the new Director-General - due to take office in July 2017 - more transparent. The programmes of the candidates and the questions posed by Member States and many other stakeholders in global health draw attention to the many challenges faced by the Organization. This paper contributes to this debate by identifying major trends in governing the global health domain which provide leadership opportunities for WHO in global health.

In this paper we highlight 10 developments that have contributed to significant changes in the global health domain. Based on this analysis we identify two closely related megatrends which have emerged over the last 10-15 years: first, a shift in the *locus* of governance to new political spaces and, second, a shift in the *processes* of governance in which a dynamic range of political and policy interests are negotiated by an increasingly dense network of alliances and coalitions.

WHO's future as a leader in global health, notably in addressing the two key challenges of our time - **health security** and **health in the 2030 Agenda for Sustainable Development** - will depend in large part on the ability of its new leadership to effectively navigate in this new, more fluid, less hierarchical governance environment.

In this changed environment WHO can gain new relevance along three axes of global governance:

- **a trusted normative authority and centre of excellence that works to position health** as a central feature of the global political landscape where decisions on global health are taken by heads of state/government and other sectors;
- **a reliable actor in prevention, preparedness and response to health crises;** and
- **a critical hub of network governance for the health dimension of the SDGs** working as a facilitator to increase synergy and collaboration among all stakeholders in global health.

Key governance messages:

- 1. Threats to global health security remain one of the most powerful drivers of change in global health regimes:** *the political attention to security responses post-Ebola and in relation to AMR must be used by WHO and other global health actors to position health firmly in "high" politics and to shape the debate in ways that move beyond a narrow security paradigm to promote resilience, sustainability, integration, equity and human security, with a focus on the most vulnerable.*
- 2. The 2030 Agenda for Sustainable Development and the SDGs provide a powerful framework to advance the global health agenda with other key global governance actors:** *the dynamics for new governance mechanisms at the global and country levels that acknowledge a) the relations between sectors and b) the changed relations between states and other actors must be used by WHO and other global health actors to position health prominently as contributing to human rights, equity (leave no one behind), environmental challenges (planetary health), sustainable production and consumption, economic impact and the broader determinants of wellbeing.*
- 3. WHO remains a distinctive and critical institution in the global health domain with a strong mandate for leadership, normative action and convening power, this now includes its new role in emergency response:** *WHO needs strong political and financial support - including increased assessed contributions - to develop its untapped potential and to play to its strengths in response to the two megatrends in the global health domain and beyond; a new Director-General must be a leader for health as a global public good, engage WHO in network governance and strengthen its convening power.*
- 4. The growing number of political bodies and institutions involved in governing the global health domain reflects an overall trend in global governance more generally towards politicisation, flexibility and partnerships:** *political support and financial resources for global health will increasingly flow to strong alliances and flexible networks which have the determination and purpose to address political priorities, support the SDGs and invest in global public goods for health, including health and human security. The increasing role of the Global South will shift political influence, composition, priorities and approaches. WHO must become a more strategic organisation.*

5. **Global health's complex dynamic system of hybrid structures, relationships and networks will continue to expand as new pressing issues enter the global governance arena and new actors gain influence:** *network governance requires investment in common goals (SDGs), joint learning and high levels of accountability through independent scrutiny of outputs and institutional performance and in the creation of hubs and platforms (including at the World Health Assembly) where learning and exchange takes place.*

6. **Global health financing will be subject to major shifts in relation to sources of funding, types and mechanisms of funding, balance between domestic and international funding and financing of global public goods.** *One of the key challenges will be the shift from classic development aid ("donors") to sustainable health investment strategies linked to determinants of health, institution building, systems such as UHC, and the financing of programmes for the poorest in emerging economies as well as mobile populations. This will impact the funding strategies of development banks as well as global philanthropies. The growth of the global health economy and the interface of domestic and global financing streams will have significant impact on priority setting.*

Keywords

Global health, governance, development, health security, SDGs, global public goods, network governance, health financing, leadership, WHO, UN

NEW DIRECTIONS IN GOVERNING THE GLOBAL HEALTH DOMAIN - LEADERSHIP CHALLENGES FOR WHO

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1. Introduction

The way global health is governed is of great practical importance. It matters, and it impacts on peoples' lives all around the world, especially the most vulnerable. Global governance addresses issues that have become too complex for a single state to manage alone. In health this applies to an increasing number of determinants, diseases, processes, products and services which today are dealt with by a wide array of institutions and agencies at the global level.

Global governance has undergone significant changes in the last decades. New features that are experienced in the governance of the global health domain can be found in many other arenas of global governance - climate change and the environment being the most obvious. There are more actors, more initiatives and a wide variety of approaches to financing. No global issue can be governed by just one organisation and many of the institutions put in place in the post-war era are being challenged to change and reinvent themselves - including WHO. This is also a key message of the Sustainable Development Goals.

Global governance takes many forms ranging from binding agreements and treaties to voluntary codes. It is conducted both by established organisations as well as fluid structures, alliances and virtual networks. Experience has shown that there is no one-size-fits-all approach to global governance and there is great innovative drive in developing new instruments and mechanisms. This is the challenge of multilateralism in the 21st century. Yet there are still many misunderstandings in relation to global governance. As globalisation is regarded more critically so are global institutions and processes, especially if they are seen as being divorced from national policies and local needs.

One defining characteristic of present day governance is too often neglected: the increasing entanglement of domestic and international politics and the need to simultaneously reach consensus at the national and the international level in order to ensure implementation. It is

positions taken at the national level that can accelerate or delay the negotiation or the implementation of global agreements. In global health the most obvious examples are the implementation (or lack thereof) of the International Health Regulations or the Framework Convention on Tobacco Control.

We argue that all global health begins and ends at home.² Therefore this paper is addressed not only to actors at the global level, but also seeks to reach out to decision-makers and stakeholders at the national level to increase their understanding of global governance institutions and processes that support health. The introduction of new financing models will be key to this interface.

In this paper we identify 10 significant developments that have contributed to the great shifts we have experienced in the global health domain. Based on this analysis we identify two closely related governance megatrends, which have emerged and consolidated over the last 10-15 years: first, a shift in the *locus* of governance to new political spaces and, second, a shift in the *processes* of governance in which a dynamic range of political and policy interests are negotiated (and then implemented) by an increasingly dense network of alliances and coalitions.

One key driver has been crisis and health security; another is the realisation that issues that were considered “low” politics - such as health and the environment - are now critical for the survival and economic development of states. Losses in GDP related to outbreaks³, NCDs or stunting will have significant influence on economic and social development. In addition a number of significant changes of global governance arrangements in general⁴ - including the adoption of the SDGs - are also shifting the main game of global health to other actors. An unresolved challenge is the role of the private sector: too many companies have yet to address their health responsibilities in the business models they use to generate revenues and continue their strategies to “*promote products and choices that are detrimental to health*”⁵.

WHO’s future as a leader in global health - notably in addressing **health security** and **health in the 2030 Agenda for Sustainable Development** - will depend in large part on the ability of its new leadership to effectively navigate in this new, more fluid, less hierarchical governance environment.

2. How do we define global health?

We propose to use a definition of global health that captures the present complexity of the global health domain. We therefore define global health as “*those issues, which transcend national boundaries and governments and call for actions on the global forces and global flows that determine the health of people*”⁶. This definition of global health covers **four key components all of which shape governance of the global health domain**:

- its starting point is the *interconnectedness* and *interdependence* between countries, reflecting global health’s origins in measures to protect people from the spread of infection;
- equally important, the definition refers to *forces and flows*, which allows it to be dynamic and cover flows of finance, goods, services and people; it thus includes issues such as illicit financial flows, migration, or the spread of noncommunicable diseases through the marketing of unhealthy products;
- additionally, it moves on from governance as a means of protection from the direct causes of disease, to governance as a means of addressing the *determinants* of health; and
- finally it recognises that action in global health needs to move *beyond governments*.

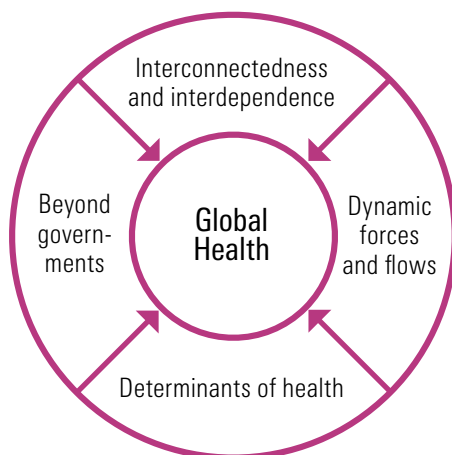


Fig 1: Four key components in the definition of global health

This definition of global health **reflects the shift to “global” from what was previously referred to as “international” health.**⁷ This has significant governance repercussions, especially as regards the governance of global public goods.

- The substantive change is **to shift the focus from health in developing countries, to a focus on health issues of concern in all countries, and all the means** (and not just development assistance and philanthropy) by which they can be addressed. It aims to move global health beyond an approach based on charity to collective responsibilities and towards global public goods and collective action. This will require involvement of the private sector, new types of financing and loans through development banks and creation of fiscal space through a significant reduction of illicit financial flows.

- The shift from “international” to “global” matches **the shift that has taken place in defining globally relevant SDGs, as opposed to MDGs** that were to be achieved by “developing” countries with support from the “developed” world. This is further reflected in the recent decision by the World Bank to drop the term “developing countries” in the 2016 edition of its World Development Indicators and to no longer distinguish between “developed” countries and “developing” ones in the presentation of its data⁸, which will also influence global health organisations.

3. How do we understand governance?

By referring to *actions on the global forces and global flows that determine the health of people* the definition of global health that we have proposed above enters straight into the challenges of governing the global health domain. **It highlights that global health must concern itself with the political choices that create or mitigate global health risks and enable or constrain effective global health action.**

It is useful to differentiate three governance spaces in the global health domain. *The term "global health governance" is applied to institutions - old and new - whose primary mandate is focused on improving global health.* While this governance space continues to be relevant our analysis concludes that they will need to be increasingly active in the political spaces that engage in "global governance for health". This includes high-level political decision-making bodies and political clubs as well as the many bodies and institutions with a broader or non-health mandate but whose policies and decisions impact on health.^{9, 10} Finally we refer to the governance processes at the domestic and regional level that influence global health action in so many ways. There is a very dynamic interface between these three governance spaces:



Fig 2: The dynamic interface between three governance spaces of the global health domain (Source: Kickbusch and Cassar Szabo 2014)⁹

The political processes that drive the interface of the three gears have been analysed by The Lancet—University of Oslo Commission on Global Governance for Health using the term “**political determinants of health**”. The Commission’s report examines the power disparities and dynamics across a range of policy areas that affect health and that require improved global governance: “*economic crises and austerity measures, knowledge and intellectual property, foreign investment treaties, food security, transnational corporate activity, irregular migration, and violent conflict*”¹¹.

In the following we will briefly outline the three governance spaces:

Global Health Governance

Global health governance started with ad hoc arrangements to contain the threat of communicable disease, then more formally through treaties, conventions, international and regional institutions, through the establishment of WHO¹² and now through a variety of other formal and informal mechanisms. The governance of institutions that have health as their primary purpose is the subject of much of the current literature.¹³

Global health governance is defined by the fact that it is one of the few global areas of concern with its own dedicated international agency with treaty making powers. WHO continues to serve as the main global health governance venue, but this governance role has been repeatedly contested. In addition, WHO is increasingly pressured into assuming different roles as the context for global health changes - at present these pressures urge WHO to take on more implementing and operational functions in relation to health security.

From its originally narrow focus, global health governance has become infinitely more complex. It is no longer the preserve of nation states - a wide array of actors and stakeholders now influence decision-making at the global level. It has increasingly been concerned with fairness, equity, human rights and the determinants of health. Its focus is not just on the USD 38 billion spent on aid for health¹⁴ - global health governance now takes into account health as a global industry worth over USD 6.9 trillion and as one of the world’s largest sources of employment¹⁵.

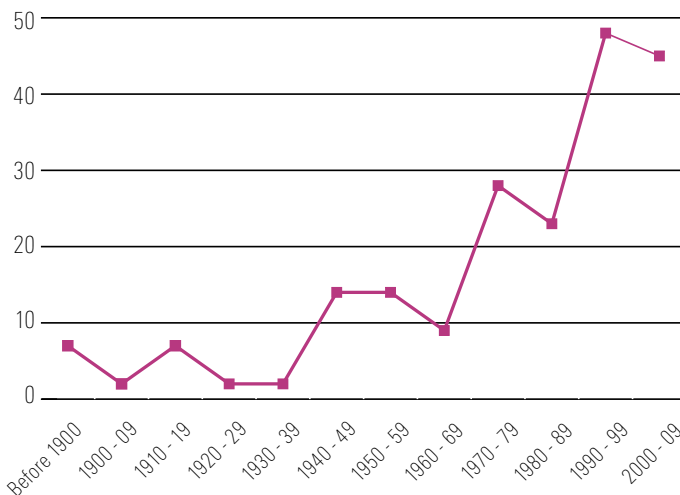


Fig 3: Inception of new global health actors by decade (Source: Hoffman, Cole and Pearcey 2015)¹⁶

The institutional landscape of organisations concerned with global health, of which WHO is but one part, has been transformed over the last 15 years, notably by the creation of a range of hybrid public-private partnerships (such as GAVI and the Global Fund to Fight AIDS, TB and Malaria) and the growing influence of major philanthropies.¹⁷

Global Governance for Health

The concept of *global governance for health* (i.e. the governance of sectors and other policy regimes that have the potential to impact on health) has more recent origins, but the fundamental issues with which it is concerned are not new.¹⁸ Agreements made at the World Trade Organization influence access to medicines. Efforts to adapt to or mitigate climate change influence the health of millions. The first WHO report focusing on the implementation of the SDGs concludes that “*it is essential to revisit and reshape the architecture for global health, particularly in relation to health security and the development of global public goods*”¹⁹.

The outcome document of the UN Conference on Sustainable Development (Rio+20) adopted by the UN General Assembly, emphasised that “*health is a precondition for and an outcome and indicator of all three [economic, social, and environmental] political spaces of sustainable development*”²⁰. Global governance for health echoes the challenge set by the 2030 Agenda for Sustainable Development that calls for **transformative policies and approaches** to address

the 17 “*integrated and indivisible*” goals. For Goal 3 “*to ensure healthy lives and promote well-being for all at all ages*”, WHO calls for cross-cutting approaches to monitor the achievement of the health targets²¹ and sees the SDGs as “*a new and exciting opportunity to strengthen governance for health - the underlying assumption of which is that deliberate action is needed to influence governance in other policy arenas to protect and promote health*”²¹.

Good global health begins at home

“Governance for global health”⁹ refers to the institutions and mechanisms established at the national and regional levels that contribute to the overall governance of the global health domain. Such mechanisms - sometimes referred to as national global health strategies or policies - bring together different sectors and stakeholders to address global health challenges that cut across traditional policy areas.

Regional political and integration bodies give support to global strategies, adapting them to the needs of their own Member States. For example the African Union has endorsed the Africa Coalition for Maternal, Newborn and Child Health as part of the Global Every Woman Every Child Strategy²² seeking to ensure a more coordinated approach across the continent. The European Union has been a powerful voice in favour of better governance of development assistance, and as a promoter of health in all policies.²³ It is nevertheless evident that the effectiveness of regional bodies varies considerably.

There is also an extensive history of countries setting up governance mechanisms to address global health priorities that require inputs from different sectors. Over the last several decades we have seen - with very varying degrees of success - population commissions, nutrition commissions and, more recently, HIV/AIDS commissions. While not considered in detail in this paper, an emerging trend is the establishment of coordinating bodies to oversee the implementation and monitoring of the SDGs - the most recent expression of governance for global health (and sustainable development) at the country level.

This underlines our point that increasingly governance for global health is a two-way street. We now see countries - China, Switzerland, the UK and many others - that seek to exercise influence on global processes through the development of their own national global health policies and strategies. The goal is to improve their global negotiation power as well as domestic support for global engagement²⁴. In a similar vein, Norway with a group of six other countries has promoted the idea of health as a foreign policy issue at the UNGA²⁵.

4. Ten trends: a sense of history

Governing the global health domain is a highly dynamic and evolving process. To get a sense of where future opportunities lie, it is useful to understand some of the changes that have taken place over the last two decades and relate them to larger changes that have occurred in global governance overall.

In the following we identify ten trends in the governance of the global health domain, which have fed into the two megatrends - new political spaces and dynamic alignments - mentioned in section 1, starting from the mid-1990s with the creation of UNAIDS. These trends overlap in time, sometimes run in parallel and influence one another. We also see knock-on as well as learning effects as the impact of one trend creates momentum for the next. For instance, the search for better coordination through the International Health Partnership has been a response to the inertia resulting from the creation of multiple partnerships.

Trend 1: Expansion: Health is a many-sectored thing

The AIDS crisis forced the world to think about the governance structures needed for a more effective global response. Specifically the need for:

- multisectoral engagement;
- high-level political support; and
- governing bodies that included civil society and the countries and communities most affected by the epidemic.

"AIDS changed everything" as the saying in global health goes - and the three elements that were needed for an effective response to the pandemic are now an essential part of the response to any major health issue such as NCDs.

The new approach to the **composition of governing bodies** championed by UNAIDS was a watershed: GAVI, established three years later, followed the same trend, with a more inclusive governing board (albeit one that focused more on private sector entities and individuals). Similarly, a more inclusive governing board was a defining feature of the Global Fund to Fight AIDS, TB and Malaria as well as the malaria and TB²⁶ partnerships (and other subsequent partnerships) established within WHO.

Multisectorality and **high-level political support** are now widely accepted and seen as essential in addressing issues such as NCDs, AMR, and health security. This is one of the reasons why major health issues make their way to the United Nations in New York. In consequence all UNGA statements on these issues underline multisectorality, including the three political declarations on HIV/AIDS^{27, 28, 29}, the declaration on the prevention and control of noncommunicable diseases³⁰, and the more recent one on antimicrobial resistance³¹.

WHO itself continues to be governed by Member State representatives, mainly from ministries of health. Successive attempts to create more diverse mechanisms (such as the proposed Committee C³² and the World Health Forum³³) have met with little success, which consequently opened up the debate on FENSA. A new Director-General will be challenged to move forward, as the implementation of the SDGs can only be achieved through new alliances and multisectoral strategies.

Trend 2: Investment: Serious progress needs serious money

The end of the 1990s saw a massive change in thinking about financing for health.³⁴ WHO DG Gro Harlem Brundtland, using the experience of her work in sustainable development, convened the Commission on Macroeconomics and Health (CMH) to bring health to the attention of heads of state/government and finance ministers. Others echoed the messages from the CMH. *"We need billions, not millions"*³⁵, said Peter Piot at the AIDS conference in Durban and was backed by UNSG Kofi Annan. This message is consistent until today - most recently in relation to the investments required in health security and implementation of IHR capacities.

Histories of the Global Fund to Fight AIDS, TB and Malaria³⁶ provide an instructive reading as to how the need for more concessionary finance influenced global health governance. From the start, serious fault lines emerged: between G8 members about ownership and the purpose of the new Fund; between countries for and against excluding UN agencies from the Fund's governance; between supporters and opponents of the governance role of civil society and the private sector, particularly the pharmaceutical industry; between different approaches to eligibility, appraisal of projects, and accountability.

The Global Fund has been through many changes since its establishment in 2002. But many of the precedents and trends it set, such as its off-shore, proposal-driven, independently-assessed approaches to managing appraisal and approval have set a pattern that other partnerships, most recently the Global Financing Facility (GFF) in support of Every Woman Every Child, have followed. Moreover, the nexus of conflicting interests that were present at

the Fund's foundation underpin the deadlock that still bedevils attempts to change the basic (donor vs. implementer) structure of the Board.

A defining governance characteristic for partnerships like GFATM or GAVI is that financial support is linked to GNI. Once a threshold has been reached then a process of "graduation" begins. However, there is no guarantee that health indicators keep pace with economic growth and, indeed, the majority of poor people live in emerging economies. New approaches that maintain a closer link between health outcomes and financing strategies will therefore be required.³⁷

Direct contributions also came from the Bill & Melinda Gates Foundation, whose entrance into global health in 1999 signalled "serious money" and shifted the power balance of the global health system. Its USD 750 million pledges made the establishment of GAVI a reality and its other investments also made possible and influenced many other programmes and initiatives, for example GPEI in the case of polio eradication. Today it is the second largest donor to WHO.

Along with the creation of PEPFAR, a significant increase in financial resources went to global health between 2000 and 2010. Subsequently, different innovative mechanisms including the International Finance Facility for Immunization (IFFIm) and Advance Market Commitment (AMC) programme at GAVI, the solidarity contribution model of UNITAID, as well as the Debt4Health and (Product) RED initiatives at the Global Fund emerged after the concept of innovative financing for development was introduced at the first International Conference on Financing for Development in Monterrey. Reinforcing this trend, each new initiative has brought its own governance requirements, yielding different innovative governance models that many see WHO falls short of.

But these major innovations will not suffice to implement the Sustainable Development Agenda for health nor to enable countries to fully implement the requirements to ensure health security. Peter Piot's dictum "*we need billions*"³⁵ holds even more today. As this will not be achieved through development aid a new debate has opened up on insurance based financing models for health security (e.g. the Pandemic Emergency Financing Facility, a reinsurance vehicle launched by the World Bank together with Swiss Re and Munich Re) and increased concessional finance for health systems investments. It has also led to a new proposal³⁸ to increase the assessed contributions to WHO.

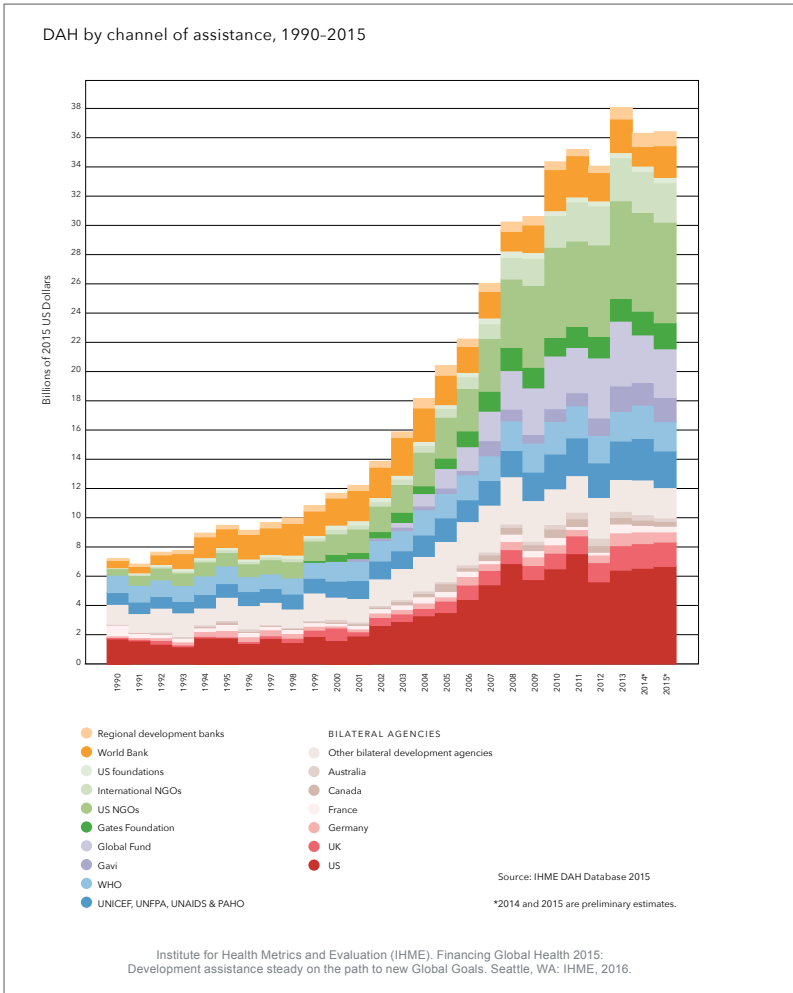


Fig 4: Development assistance for health by channel of assistance, 1990-2015
(Source: IHME - Financing Global Health 2015)¹⁴

Trend 3: Binding states: a stronger normative role for WHO?

Recommendations and other non-binding standards are the mainstay of WHO's normative work. They are non-binding, can be adapted to local circumstances, and depend on WHO's technical standing for their credibility. But the World Health Assembly can also adopt conventions with respect to any matters within the competence of the Organization, which once ratified become binding; and regulations within specified areas, which enter into force for all Member States unless they register a specific opt-out.

In 1998 work began on the WHO Framework Convention for Tobacco Control (FCTC). The Framework was adopted in 2003, entered into force in 2005 and currently has 180 parties. In 2012 the Conference of the Parties adopted an additional protocol on illicit trade in tobacco products. Most recently, in 2016, India hosted the seventh session of the COP to review the implementation of the FCTC and the additional protocol. On the other hand, in 2005, the International Health Regulations were revised in order to address the public health aspects of any health threat regardless of origin or source. In 2011, after protracted negotiations over several years, the WHA adopted the Pandemic Influenza Preparedness (PIP) Framework, which governs virus and benefit sharing when new flu vaccines are needed. In both cases there is a gap between acceptance/ratification and implementation.

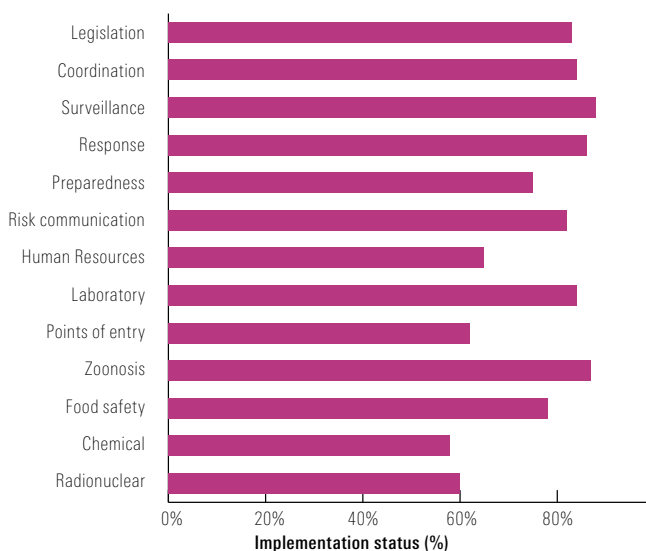


Fig 5: IHR core capacities implementation status, 2015 (127 reporting countries)
(Source: WHO Global Health Observatory)³⁹

The move towards using more binding instruments in global health governance is important for other reasons. While - as we have indicated - there has been significant analysis how the international response to HIV/AIDS changed global health, the impact of the first treaties on global health is still largely unexplored. The FCTC and its first protocol (Protocol to Eliminate Illicit Trade in Tobacco Products) show that it is possible for a health organisation to convene a process that deals with issues of taxation, trade and law enforcement from both a practical and constitutional perspective.⁴⁰ The International Health Regulations have been equally influential and require relationships to be established with other sectors (airlines, port authorities, security, customs etc.). However, the experience of Ebola has shown that too often the IHR are seen purely as being of importance to public health officials, with the result that they are not taken into account by other agencies especially in relation to travel and trade restrictions.

The FCTC, WHO's first international convention, "unlocked" the **treaty-making power of WHO** contained in its Constitution and has built an appetite - if tobacco, why not alcohol, or sugar? Advocates for a Framework Convention on Global Health⁴¹ argue for a binding instrument that would stipulate minimum levels of health care provision and finance for all countries. A proposal for mandatory contributions to a global fund for research and development⁴² has been debated for years - but never resolved. With AMR as a potential candidate for a global treaty, these are important questions for the WHO governing bodies to consider as they pit the desirability of enforceable, binding arrangements against the time needed and the political, institutional and financial cost of negotiations.⁴⁰

Trend 4: Mergers and acquisitions - the search for better coordination

Attempts to reform the global development system in which health is a key player follow a consistent pattern over the last decade. Within the UN, reform started from the premise that there were too many competing entities within the UN development system. However, Member States pushed back at the idea of mergers (with the exception of UN Women) and thus reform has been consigned to an ever more complex process of joint planning at the country level under the rubric of One UN and Delivering as One.

While reform of the UN system led by the UN Development Group remains obsessed with *coherence*, many donors to the UN are urging specialised agencies to demonstrate more clearly their individual *relevance*.⁴³ Staff at the country level therefore receives conflicting messages: on one hand, joint planning and monitoring, blurring agency boundaries and, on the other, clear agency-specific attribution of deliverable and results.

In the wider system a similar pattern prevails. Health has been featured prominently in debates on aid effectiveness in the sequence of High-Level Forums that took place in Paris, Accra and Busan. Rationalising the roles and responsibilities of agencies directly engaged in global health was one of the objectives of UNAIDS-Lancet Commission⁴⁴ that sought to use lessons learned from AIDS in shaping a new agenda and architecture for global health, but it has had little impact. Thus, as for the coordination of health agencies within the UN system, governance is left to the country level - sometimes in a structured way through initiatives such as the recently renewed International Health Partnership (IHP+) - or, more often, through local efforts.

Improving WHO's performance at the country level has been an important aspect of recent reforms. However, while the objectives of reform have been framed in terms of putting in place the people and systems required to make WHO country offices a strategic partner of governments as well as an effective facilitator in countries with many development partners, progress has been slow and patchy. It has not helped that many of WHO's country operations are dependent on finance coming from GAVI and the Global Fund, effectively putting the Organization in the role of contractor (with the administrative burdens that this entails). The Ebola crisis has led to a renewed probing of the role of the WHO country offices and how they will function in the context of a new emergency programme of the WHO.

Trend 5: Outbreaks and emergencies: whose security?

The trend that has defined global health governance (and its failures) more than any other in recent years has been the world's response to outbreaks and epidemics: SARS, Avian flu, H1N1, Ebola Virus Disease, and Zika. Acute health crises, as we saw with AIDS, if they threaten global security, drive change and do so rapidly. The risk, of course, is that the changes that come about see global health governance purely through the lens of outbreak response.

Pandemic influenza and SARS were primarily *health* crises. While they had major economic impacts, with only a few exceptions they did not cause major humanitarian disasters. Outbreaks like polio or cholera in Syria and several other countries affected by acute or chronic conflict were predominantly *humanitarian* crises. They have a major impact on peoples' health, where health is an integral part of the response but not in a leadership role.

In 2014 when Ebola reached the cities of West Africa, it was simultaneously a *health and humanitarian* crisis, but treated by WHO primarily as the former. However, concurrent with the outbreak was the political turmoil and the scars of civil wars in Liberia, Sierra Leone and Guinea. The failure to bring in the assets of the humanitarian sector and to recognise the need

for a global response at the highest levels of government in the affected countries and beyond underpins many of the critiques that have followed the crisis. By contrast, when WHO exploited its traditional strengths in convening to promote the production of diagnostics and vaccines with extraordinary speed, its work has been generally applauded.⁴⁵

Efforts to counteract the negative impacts of outbreaks will continue to dominate in the global health domain - for example they continue to be on the G7 and the G20 agenda, the USA is leading a major Global Health Security Agenda with many partners, the World Bank is exploring new funding models for outbreaks, and the UNSG has established a task force on health crisis. But the perception of many developing countries remains that major investment is only forthcoming when it protects the economies of high-income countries. It is therefore important for WHO together with others to ensure investment in preparedness and resilience, to convince its Member States when trade-offs have to be made, to counter-act free riders and ensure that the costs and benefits of health security are shared in an equitable way.

Trend 6: First we take Manhattan...

Starting with HIV/AIDS an increasing number of health issues have found their way to the United Nations in New York - in large part because they cannot be resolved by the health sector alone and need the political clout of "high politics". The UN Security Council has so far discussed three health issues - HIV/AIDS^{46, 47}, Ebola⁴⁸ and, more recently, the protection of hospitals and health workers during conflict⁴⁹. Increasingly the debate of a health issue at the UN General Assembly is seen as a signal of the importance of the issues concerned, so there is competition for more to follow. Even if issues do not make it to the UNGA itself, the week around the opening of the General Assembly in September now has a dense schedule of health events, an illustration of the widening political space for global health. This has increased since the adoption of the MDGs (three of which related to health) and continues with the health dimensions of the SDGs. It also implies greater cooperation with other New York-based UN agencies such as UNDP, UNICEF, UN Women, UNOCHA and UNFPA.

In governance terms there are clear advantages in elevating issues so they reach the attention of heads of state/government and foreign ministers as suggested in Trend 1. Also, the Global Health and Foreign Policy Initiative²⁵ mentioned in the previous section was specifically designed to make the case of health as a foreign policy issue and ensure a regular debate of global health at the UNGA. There is little doubt that the fight to combat NCDs has been helped by two resolutions^{50, 51} of the General Assembly, as has the UN High-Level Meeting on NCDs. Other issues, most critically AMR, have recently been debated at the UNGA. In addition, the

Secretary General has used other means to elevate the cause of health: through his sponsorship of the Every Woman Every Child Partnership and through convening high-level panels or commissions on key issues - most recently on the Global Response to Health Crises, Access to Medicines, and Health Employment and Economic Growth. Finally health is gaining increased consideration in ECOSOC through processes related to the SDGs, such as the High-Level Political Forum created to track and advance their implementation.

Despite these advantages, the degree to which greater involvement of UNGA and - consequently - New York missions of Member States in health issues is always positive for health needs to be thought through strategically. There is the risk, for example, that health is made subordinate to the predominant political concerns of the UNGA, particularly security. Missions in New York are rarely well briefed on health issues and entrenched fault lines between voting blocs, irrespective of the issue at hand, can often dominate debate. Nevertheless, the Geneva - New York axis is gaining increasing importance for governing the global health domain: it changes the relationship between WHO and the UN; the DG and the SG; and, for representatives in the respective permanent missions it requires much closer liaison between Geneva, New York and national capitals.

Trend 7: Involvement of heads of state/government and political blocks: the role of the G7 and G20

The G8 (as was) had a major influence in global health towards the end of the last century and the start of this one. Beginning with support for malaria control, the G8 played a significant role in the creation of the Global Fund. After a relatively quiet interlude the G7 has become once again a significant force in global health. Health security and universal health coverage became important topics at the G7 summits of Germany in Schloss Elmau 2015 and of Japan in Ise-shima 2016. In addition, German Chancellor Angela Merkel and WHO DG Margaret Chan launched the “Healthy Systems – Healthy Lives” initiative at the UNGA in September 2015 to accelerate global cooperation on strengthening health systems. The Hangzhou G20 summit 2016 also issued a strong statement on AMR in its final communiqué and the Hamburg G20 summit next year will again prioritise global health. For the first time, there will be a meeting of health ministers, and that the Director-General of WHO being invited to attend a G20 summit is also unprecedented.

The significance of G7/G20 involvement is that it immediately casts health as an issue of global importance. It is also noticeable that the focus of engagement has broadened: from security (AIDS and now AMR) to women and children’s health and health systems. The trend for

involving former or serving heads of state/government has accelerated - as champions of particular causes (e.g. Jacques Chirac on solidarity tax) or as Chairs of UN and other Commissions (e.g. most recently François Hollande and Jacob Zuma for the UN High-Level Commission on Health Employment and Economic Growth, Joyce Banda for the UNAIDS-Lancet Commission). In Africa, first ladies have been influential in the field of HIV/AIDS and more recently in promoting the roll-out of HPV vaccines. Ambassadors from several Permanent Missions in Geneva have also been enormously influential in the cause of global health, lending their diplomatic expertise to help resolve contentious issues. This politicisation of global health constitutes a major trend and provides both an opportunity and a challenge to WHO leadership in global health.

Trend 8: Calls for greater Accountability - but to whom?

An interesting thread ties together the 2010 Muskoka G8 summit in Canada and the burgeoning of interest in a more political approach to accountability that has followed. Prior to the summit the G8 had received criticisms (particularly following the Gleneagles "Make Poverty History" summit in 2005) from civil society groups complaining that statements in successive communiqués were never followed through. A G7/8 Accountability Working Group has been established since then to review its development-related commitments. Canada as G8 President in 2010 was keen to support health, focusing on maternal and child mortality. The Muskoka Initiative was therefore set up (almost like a discrete project), which then joined forces with the larger Every Woman Every Child Partnership promoted by the UNSG and brought its concern for greater accountability along with it. The WHO DG agreed to convene the high-level Commission on Information and Accountability, which recommended amongst other things the establishment of the independent Expert Review Group (iERG).

The iERG has inspired interest in the idea of independent (as opposed to mutual) accountability as a powerful tool for commenting on the performance of international organisations and their domestic partners. On the other hand, this approach also received a boost when the Global Polio Eradication Initiative asked an Independent Monitoring Board (IMB-GPEI) to review faltering progress in eradication in key countries. Through some exceptionally plain speaking about the agencies involved and the governments with whom they were working, the IMB has had a significant impact. Following this direction an independent oversight board has also been established for the WHO emergency programme.

From the perspective of trends in global governance, independent monitoring of performance is hardly a new idea. Where there does seem to have been a change is to broaden the remit

of accountability from using data primarily to establish outcome and impact as objective measures of performance, to more critically examining different aspects of institutional performance and political commitments. The experience of iERG and IMG-GPEI raises two important issues. First, how broad or narrow should the remit of such groups be? The risk being that for each health topic a new mechanism will be proposed. Secondly, the notion of “independence” is a very slippery concept: independence from whom or what?

The reporting processes to be put in place through the SDGs will add new accountability both of Member States and international agencies. This addresses the weakest link of global health accountability: that of the Member States themselves. This issue has come to the fore again in relation to the implementation of the IHR capacities or the WHO Contingency Fund for Emergencies. The role of civil society and academia in tracking Member States becomes indispensable.

Trend 9: Keeping the public in public health

Multiple stakeholders are involved in global health governance as indicated in Trend 1. Civil society networks, individual NGOs at the international down to community level, professional associations, the media, think tanks, national and transnational corporations, the individuals and informal diffuse communities that have found a new voice and influence thanks to ICT and social media - all of these actors influence decision-making.

For inter-governmental bodies like WHO this trend is challenging, requiring them to ensure the primacy of Member States in making policy decisions and to protect normative and standard setting work from any vested interests, while still finding ways of engaging with all parties. If the Director-General berates industry and warns Member States from the podium that “*public health must contend with Big Food, Big Soda and Big Alcohol*”⁵² it should be no surprise that some of the same Member States then question WHO’s right to engage freely with “non-state actors”. A key concern centres on defining those NGOs that represent public interest as opposed to business interests. Those that differentiate between so-called PINGOs and BINGOs⁵³ insist that a clear dividing line is possible. Others point out that such differentiation is very much in the eye of the beholder, and very difficult to do so in any objective way.

Much of the protracted debate, which ended with a legal text⁵⁴ - the Framework of Engagement with Non-State Actors (FENSA) - seeks to bridge what is in effect an ideological divide, particularly with regard to engagement with private sector interests. It thus remains to be seen whether FENSA opens and clarifies the political space in which WHO is able to engage with non-state actors or whether it has the effect of closing it down.

Trend 10: Everything is connected to everything else: but how?

Aligning with the 2030 Agenda for Sustainable Development is the new mantra for public health. The principle that goals are integrated and indivisible; that they are relevant to all countries; that development should be country-led; and that equity - no-one being left behind - should be a prime concern, provides a ready-made charter for better governance for health.

The question is what this will mean in institutional terms at the global and country levels. So far, at the global level, the focus is on indicators and ways in which they will be monitored. This is necessary, but comes with the risk that the detailed quantitative reporting at overly frequent intervals means losing sight of the bigger picture.

Also missing are mechanisms to manage trade-offs, and the means to ensure that what is needed to achieve one goal does not conflict with what is needed to achieve another. For example: Can strategies to promote sustainable production also help to reduce road traffic accidents and NCDs? Or how can employment legislation be adjusted in order to strengthen and not undermine health systems? Without effective mechanisms that manage and negotiate the interdependence between 17 different goals, little will have changed.

One of the major criticisms of the MDGs is that they encouraged supporters of each goal and target to think only about their own particular concerns. The SDGs offer a way out of this, but they do not suggest how it should be done. For WHO the SDGs provide the full legitimacy to move beyond ministries of health - how it rises to this critical challenge will set the tone for governing the global health domain.

5. How do these trends relate to larger trends in global governance

It would be remiss of us to consider the developments in the global health domain in isolation from the overall trends seen in the broader field of international relations. We see commonalities in global health and in the environment, for example, with new types of agencies and actors, new mechanisms and institutions, and increasing segmentation and fragmentation⁵⁵. Two trends in global governance are particularly relevant.

The first is a function of geopolitical shifts in power and influence. Interestingly, the success of the most recent all-country agreement - on climate change rather than health - was not driven by the Global North but by the Global South, with an increasing number of countries realising how critical global action was for their own future. Increasingly *any* agreements in the global governance arena will be dependent on the countries of the Global South. Indeed given recent political developments China might emerge as the global climate champion. In addition, new institutions such as the Asia Infrastructure Investment Bank and the BRICS Development Bank can constructively challenge the Bretton Woods Institutions.

This fulfils a long-standing requirement for a more balanced and democratic global system. The domination of Northern voices in global health discussions through different avenues including major commissions and conferences has led to calls for the global health community to become more inclusive in its thinking and working.⁵⁶ At the same time we see agreements and norms, for which there has been an established consensus between nation states for several decades, begin to be eroded. We see this, for example, in relation to the overall commitment to the multilateral system, humanitarian principles (use of torture, bombing of hospitals, rejection of the Geneva Convention); women's rights and sexual freedoms; and in the growing critique of global institutions such as the International Criminal Court. Finally - due to domestic challenges - we see reduced financial commitments from the Western donors. At present it is quite unclear where the multilateral system is heading in such a multipolar world and WHO's future will be strongly linked to developments in the overall UN system.

The second major trend concerns the future of treaty-making. While many global health advocates tend to be in favour of binding rules, wary of flexibility and sceptical of partnerships that include the private sector, there is now an equal and opposite trend emerging from recent events such as those surrounding climate change negotiations. Supporters of this view, which

is more in line with our two megatrends, argue in favour of *“flexibility over rigidity, prefer voluntary measures to binding rules and privilege partnerships over individual action”*⁴.

Indeed, in considering how to reach an agreement on AMR, WHO might be better advised to look at the Paris agreement rather than the Framework Convention on Tobacco Control or the IHR. Anne-Marie Slaughter highlights the key components of the Paris agreement, which she considers as a possible model for 21st century global governance. *“The Paris agreement is a sprawling, rolling, overlapping set of national commitments brought about by a broad conglomeration of parties and stakeholders. It is not law. It is a bold move toward public problem solving on a global scale. And it is the only approach that could work.”*⁵⁷

6. Strategic conclusions

Policy imperatives

Our first strategic conclusion is that health security and health in the 2030 Agenda for Sustainable Development, and specifically the relationship between health and the integrated and interdependent Sustainable Development Goals constitute the two main substantive policy imperatives of the new agenda. These two topics have contributed to making health a central and defining issue in a wide range of policy (and political) arenas and have been instrumental in shifting health from “low” to “high” politics.⁵⁸

- *The most powerful driver for governance change is any health event that threatens global security.* The creation of UNAIDS in the 1990s was driven by the perception that existing institutions were simply not up to the task of mounting an effective response to a pandemic that threatened economic and political interests worldwide. In terms of economic impact one could make the case that NCDs or stunting present a threat of similar magnitude. But the threat is long term and its impact is gradual. A growing burden of NCDs is thus unlikely to result in rapid changes in global governance or support for the creation of new agencies. By contrast, the circumstances that resulted in the hasty establishment of UNMEER⁵⁹ were worryingly akin to those that prevailed in the case of UNAIDS. But countries refrained from creating a new institution and rapidly resuscitated the faltering process of reform in WHO, with a singular focus on emergency response. Its result was a governance reform without funding guarantees. All discussions ever since have shown that more reliable mechanisms for pooling worldwide risks are required, but this will not be decided in WHO. It will need to gain traction in political bodies such as G7 and G20.
- *The 2030 Agenda for Sustainable Development can release health out of what too often amounts to a self-imposed sectoral silo.* The Sustainable Development Agenda (in line with the recommendations of the Lancet-University of Oslo Commission referred to in Section 3) argues for more coherent and consistent engagement between health and the other sectors and policy regimes that influence its economic, political, social and environmental determinants. It provides a new and robust platform for thinking about the relationship between health and the broader environment (planetary health); between health and sustainable economic growth; between health as a beneficiary and contributor to sustainable production and consumption; and the importance of health for a more equitable world (leaving no-one behind). The challenge, as we noted in our analysis of trends, is that none of this happens automatically. Indeed, while the reform of global governance is not short of good ideas or rational arguments in favour of change, little has actually been realised. The SDGs provide a motive, what is now needed is for the rationalists to combine forces with the more powerful drivers of change to create means and opportunities.

One major concern is that the two policy imperatives are often seen as being in opposition. Many public health advocates and some countries fear that the political forces that prioritise health security will sweep all before them, at the expense of issues such as equity and universal health coverage. This is a real concern, particularly if investment in health security is perceived as merely protecting the economies of high-income countries. In fact the two policy agendas have much in common: they depend on actors outside and beyond the traditional health space; they are accelerated and/or constrained by changing geopolitical political forces. We would maintain that progress on one is necessary for sustained progress on the other.

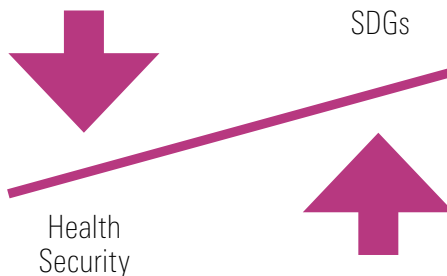


Fig 6: In search of equilibrium: two main dynamics driving political change for health

The other major concern in both agendas is not fail the most vulnerable. This includes populations in fragile settings, victims of war, refugees, asylum seekers, trafficked populations, forced labour, slaves and global migrant workers. As the interest in health security mounts the challenge of human security looms large. This underscores both the significance of the SDGs and of personal and collective health security.

Both health security and the SDGs will require innovative approaches to governance that reward interaction between sectors and institutions; that explicitly address the need to manage trade-offs and promote synergies; and that facilitate dialogue between public, private and community interests. This applies in particular to global and domestic health financing and investments which are required for both policy imperatives. For example the World Bank is presently engaged in developing the economic case for health investments in new ways: insurance models for the response to health emergencies and creation of fiscal space for health through large scale infrastructure investments.

The ministry of finance now becomes the key interface for health advocates. If next year 2017 is the first time the health ministers meet in the G20 it will be critical for them to set an agenda that will be discussed together with the G20 finance ministers in 2018. This can be the joint agenda for the new DG of WHO together with the heads of the World Bank and the IMF.

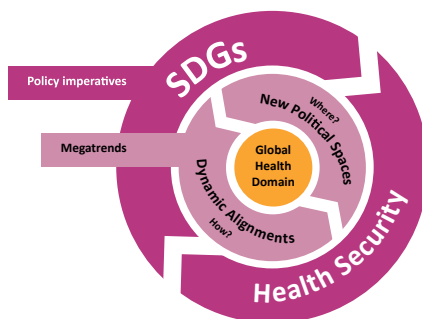


Fig 7: Policy imperatives and megatrends for governing the global health domain

Two megatrends of governing the global health domain

Building on the first strategic conclusion that health security and the SDGs constitute the two main substantive policy imperatives of the new agenda, **our second strategic conclusion is to propose two closely related megatrends that help us understand how governance of the global health domain has progressively changed over the last 10-15 years.**

These trends are a logical outcome of many of the developments that we have discussed earlier in the paper (the need for new sources of finance, multisectoral approaches, proliferation of new health actors, shifts in geopolitical power, conflicting pressures on traditional organisations, and so forth). A key point, however, is that the governance changes implied by these megatrends are key to making progress with the two policy imperatives that will continue to drive global health.

The first megatrend is a shift in the *locus* of global health governance to new political spaces and the second is a shift in the *processes* of governance in which we see a dynamic range of political and policy interests being negotiated by an increasingly dense network of alliances and coalitions.

Megatrend 1: new political spaces for global health

The “main game” of global health will increasingly be played out beyond what has been traditionally defined as the global health architecture.⁶⁰

Recent examples that illustrate this trend include: health discussions at the UN Security Council (HIV AIDS, Ebola, attack on health workers), the UN General Assembly (AIDS, NCDs, AMR), ECOSOC, high-level UN panels and commissions on global health issues, the G7 and G8 (AIDS, depression, UHC, health security, NTDs), the G20 (AMR, health security), the Human Rights Council (right to maternal health, access to medicines), WTO (IP, tobacco), the World Economic Forum, the Munich Security Conference; regional organisations such as the African Union and the European Union; as well as other political clubs such as BRICS. The World Bank and other development banks are much more involved in financing global health, whereas GAVI and the Global Fund increasingly negotiate with finance ministries as they aim to implement “transition strategies”.

Major conferences on other global priorities (climate, cities, refugees, migration, humanitarian action, labour, women’s rights) now also include health concerns. Health is a major part of soft power strategies involving the commitment of heads of state/government, such as the China-Africa strategy. In consequence health is increasingly found in the foreign policy space of countries’ policy activities. What we lack is a regular reporting mechanism that tracks this multitude of developments and seeks to analyse their outcome and their impact, or, as Inge Kaul proposes, “an *observatory of global risks and opportunities mandated to survey the global public domain*”⁶¹ that is able to incorporate interdependence management into the UN architecture.

The Rise of the Rest. Countries like China and Brazil have been major players in global health governance since the establishment of WHO in 1946. Increasingly, however, many other low- and middle-income countries and emerging economies both play an influential role in negotiations and have increased the number of locations and forums in which negotiations are conducted. Some countries like Indonesia have played a strong hand individually (for instance in the development of the PIP Framework), others exert influence through regional and sub-regional groupings (such as UNASUR or SADC). Much has been made of the growing power of the BRICS countries on the global stage. However, there is limited evidence in global health as to their effectiveness as a negotiation bloc, as opposed to the well-recognised strengths of each of the BRICS countries acting in their own individual interests, including in health.

Broader national representation in global health governance is a positive development.

While it adds to the complexity of negotiations, and on occasion to some unexpected alliances between different interest groups⁶², the legitimacy of decision-making is inevitably enhanced and rightly reflects broader shifts in geopolitical influence. Non-OECD countries have been particularly influential in the process of WHO reform, concerned that donor interests would dominate the process, and middle-income countries insisted on broader Member State leadership. Many emerging economies are strong supporters of the multilateral system, seeing it as a way to increase their leverage over global issues. This growing interest, however, is rarely matched by increases in financial contributions.⁶³

In this political space individual “issue entrepreneurs” can exert significant influence.

Some of these are obviously those in political leadership positions, such as heads of agencies and foundations. There is also an increasing tendency, almost a requirement, that heads of state/government lead high-level panels. No big meeting is complete without a celebrity or royal presence. A few individuals, however, whose names would inevitably recur throughout any in-depth history of global health governance, work in more subtle ways. An example is to contribute to agenda-setting through major global health journals. Their influence has been considerable and this type of entrepreneurship must be included when aiming to affect change.

Megatrend 2: increasingly dynamic policy alignments for global health

The dominant approach to govern the global health domain is increasingly through building and shaping cross-sectoral networks, creating hybrid organisations and enabling dynamic policy alignments, which work to voluntary rules.⁶⁴

Networks are taking the place of single organisations as agents of change. Starting with Roll Back Malaria and Stop TB a growing number of public-private partnerships have been formed to raise resources, to coordinate technical strategy and to act as advocates for their particular cause. Other more recent examples include the Every Woman Every Child Initiative, the Scaling Up Nutrition (SUN) Movement, and the Global Partnership for Sanitation and Water for All (SWA). The membership and scope of new networks have become increasingly ambitious. Thus, the increasing momentum of the Global Health Security Agenda, “a growing partnership of nearly 50 nations, international organisations and non-governmental stakeholders to help build countries’ capacity to help create a world safe and secure from infectious disease threats and elevate global health security as a national and global priority”⁶⁵, is the

prime example exhibiting how such a network governance approach promotes learning and cooperation among developed and developing countries.⁶⁶

This reflects a trend under way in the global governance of other challenges, such as the environment. It will also be critical for advancing the 2030 Agenda for Sustainable Development, which requires looking beyond the goals of individual organisations and giving priority to outcomes that depend on synergies and co-benefits and addressing interlocking crises. This will make or break the response to “wicked problems” such as AMR, mobility and migration, climate change and health, the new urban agenda etc. which can only be achieved collectively. Here the engagement with the private sector will also be pivotal especially in light of the negative externalities corporations produce when striving for their prime objective of growth and expansion. Earlier proposals have underlined that the commons - or global public goods - are best managed through networks.⁶⁷ The global health community working in this fashion can sometimes deliver alternative solutions when WHO is bogged down in political or organisational gridlock. New investment is therefore best focused on the creation of flexible alliances, that have a clear purpose, and which allow participating institutions to retain their individual identity, rather than the creation of new stand-alone organisations.

Network management is important: competition for resources can detract from good governance. The proliferation of new partnerships with multiple channels and systems for disbursing funds and monitoring results has arguably made effective governance of the global health domain more difficult as each entity competes for attention and funding. While opportunity costs arise due to fragmentation and duplication of effort on the ground, there are additional downsides from a purely governance perspective. As each new agency and partnership seeks to establish a representative high-level board, which meets two or three times a year, and as each new cause holds its high-level advocacy meetings, the pressure on ministers and other individuals mounts. It is no longer physically possible to attend all the “high-level” events to which those in a position to influence governance are invited. Inevitably the urgent (and occasionally pleasurable and lucrative) displaces the important.

Activism works better in black and white. The arguments presented for better governance are usually rational, measured and reasonable. But changing some of the more egregious examples of governance failure - getting over 15 million people on treatment for AIDS or forcing pharmaceutical companies to reduce the price of life-saving medication, for example - did not happen through reasons alone. The neglect of NCDs is linked to significant pressure on governments by commercial actors and focusing advocacy on moral outrage that can change the

behaviour of governments and their development partners is challenging. For campaigns to be successful they need to have a clear target and outcome, with heroes and villains - Big Tobacco, Big Pharma, Big Food or Big Soda. A chorus of competing interest groups will have little impact and this reinforces the importance of dynamic alignments.

Promoting accountability for performance. High levels of accountability through independent scrutiny of outputs and institutional performance are critical elements of global health governance. Mechanisms like the iERG and the Independent Monitoring Board of GPEI have made a difference and should be applied to new ventures such as the UHC Alliance and the Coalition for Epidemic Preparedness Innovations (CEPI). New investment is needed to create hubs (including at the World Health Assembly) where learning and exchange take place on the basis independent monitoring. This will in turn promote the idea of global health as a learning and adaptive system.

What does this mean for global health organisations, especially WHO?

We see a unique window of opportunity for WHO to position itself as a distinctive and critical institution given the changes we have identified. Indeed, WHO's future as a leader in global health - notably in addressing the two key policy imperatives of our time - **health security** and **health in the 2030 Agenda for Sustainable Development** - will depend in large part on the ability of its new leadership to effectively navigate in this new, more fluid, less hierarchical governance environment.

Both the SDGs for health and health security can only be achieved together with others and through strong political support. We argue that **network governance** can best capture the dynamic relationship between the many different actors and stakeholders who shape how the global health domain is governed today. Especially WHO should use its legitimacy, authority and resources to engage in network governance, and motivate others to embark on joint action by creating partnerships and networks and by acting as a network hub. This will require a fundamental change not only in how WHO acts but also how it thinks about itself.

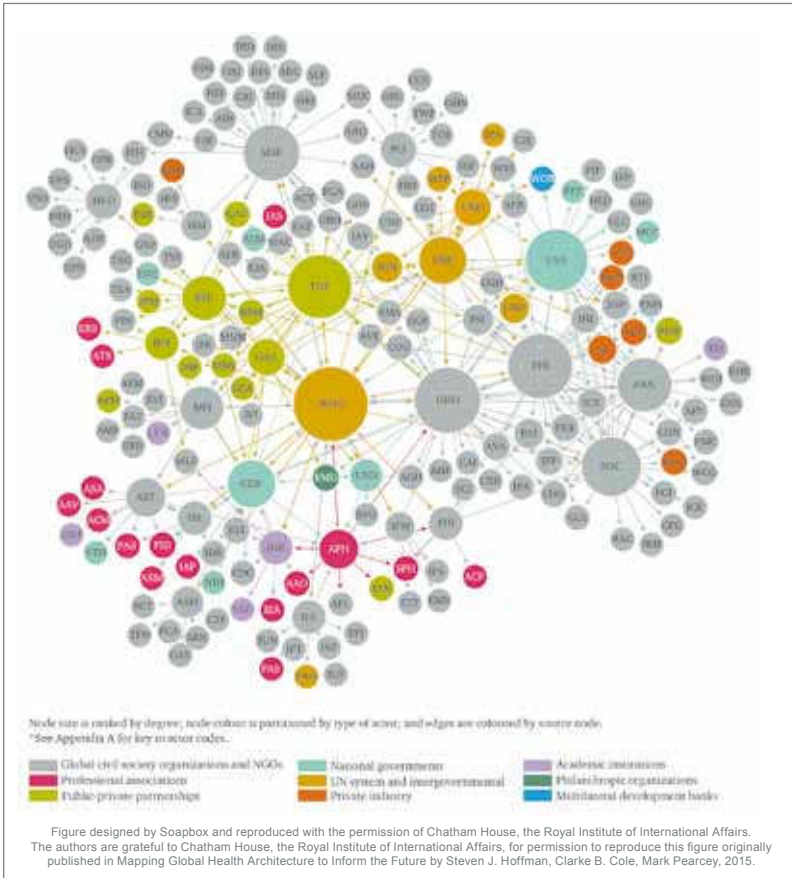


Fig 8: WHO as a network hub (Source: Hoffman, Cole and Pearcey 2015)¹⁶

The two megatrends pose their own specific challenges. The first requires astute positioning that maintains health as a key element of “high politics” in a growing number of global forms. The second requires that WHO has the capacity and incentive systems for network governance and that its senior leaders see themselves as brokers and facilitators.

It is important to recognise that many of the new mechanisms that have been proposed to enhance governance for health are based on the idea that WHO cannot or is unable to take the lead in driving political processes that bring together multiple stakeholders with health

as the central outcome. Here there is the potential for a genuine parting of the ways: WHO as a leader and powerful political actor in the interests of global health versus WHO as a technical agency maintaining a focus on a limited set of health sector outcomes. This is not a straightforward choice and whilst many see the former option as the most desirable the obstacles to be overcome in making it real are formidable. It is not easy to finance, and to be effective it requires that WHO opens up the political space to work with a range of stakeholders that many of its Member States, egged on by some civil society groups, are only too anxious to close down.

Such a move implies that the major strategic opportunities and challenges in governing the global health domain have to be systematically discussed by WHO and its governing bodies. Despite the urgency of these issues, the debate on governance of the global health domain in WHO still remains myopic and largely fixated on internal procedures. It also requires WHO to have the strategic and diplomatic competence required to deal with the new complex environment.

We argue that the two long term megatrends in global health - new political spaces and new dynamic alignments - are accelerated through the political dynamics generated by the SDGs and the health security agenda. This provides a unique opportunity to strengthen global health in general and WHO in particular. Under new leadership WHO can position itself as a leader by strategically integrating these two driving forces to strengthen the global health domain and to serve the most vulnerable.

7. Conclusion

WHO is different from other organisations and needs to be financed in a way that allows it play to its strengths. This means investing adequately in its normative and convening capacity, including its new role in emergency response. WHO should not try to duplicate functions of global partnerships, and donors to WHO should resist funding the Organization to do that which it does least well. Reform needs to be seen less as a managerial project and more as a major strategic and cultural shift. It is about confidence and the way the Organization thinks about itself. Senior managers under the next administration will need to lead by inspiration and example, and be involved in the change process. WHO has a historic opportunity to become increasingly relevant:

- **as a trusted authority and centre of excellence that works to position health** as a central feature of the global political landscape where decisions are taken by heads of state/government and other sectors;
- **a reliable actor in prevention, preparedness and response to health crisis**; and
- **a critical hub of network governance for the health dimension of the SDGs** working as a facilitator to increase synergy and collaboration among all stakeholders in global health.

Endnotes

- 1 Ilona Kickbusch is the Director of the Global Health Centre at the Graduate Institute of International and Development Studies. She is a member of the Global Health Crises Task Force established by the United Nations Secretary-General and served on the WHO Ebola Interim Assessment Panel in 2015. Andrew Cassels is Senior Fellow at the Global Health Centre and former Director of Strategy at the Director-General's Office at WHO. Austin Liu is Research Assistant at the Global Health Centre.
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Abbreviations

AMR	antimicrobial resistance
BRICS	Brazil, Russia, India, China and South Africa
COP	Conference of the Parties
DG	Director-General
ECOSOC	United Nations Economic and Social Council
FCTC	WHO Framework Convention on Tobacco Control
FENSA	WHO Framework of Engagement with Non-State Actors
GAVI	Global Alliance for Vaccines and Immunization
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	gross national income
GPEI	Global Polio Eradication Initiative
H1N1	Influenza A virus subtype H1N1
HIV/AIDS	human immunodeficiency virus infection and acquired immune deficiency syndrome
HPV	human papillomavirus
iERG	independent Expert Review Group
ICT	information and communications technology
IHR	International Health Regulations
IMF	International Monetary Fund
IP	intellectual property
MDGs	United Nations Millennium Development Goals
NCDs	noncommunicable diseases
NGOs	non-governmental organisations
NTDs	neglected tropical diseases
OECD	The Organisation for Economic Co-operation and Development
PIP	pandemic influenza preparedness
SADC	Southern African Development Community
SARS	severe acute respiratory syndrome
SDGs	United Nations Sustainable Development Goals
UHC	universal health coverage
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNASUR	The Union of South American Nations (Unión de Naciones Suramericanas)
UNDP	United Nations Development Programme

UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
UNMEER	United Nations Mission for Ebola Emergency Response
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNSG	United Nations Secretary-General
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
TB	tuberculosis
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

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