Global governance of health: conference report

Scott Burris
Leo Beletsky

Follow this and additional works at: http://lsr.nellco.org/nusl_faculty

Recommended Citation
http://lsr.nellco.org/nusl_faculty/230
THE OSI SEMINAR ON
THE GLOBAL GOVERNANCE
OF HEALTH

Schloss Arenberg
December 5-8, 2005

Conference Report

Prepared by:
Scott Burris and Leo Beletsky

Sponsored by:

TEMPLE UNIVERSITY
Beasley School of Law

Yale University
School of Medicine

OPEN SOCIETY INSTITUTE
& Soros Foundations Network

INSTITUTE FOR
INTERNATIONAL LAW
AND PUBLIC POLICY
Summary

“Governance” is the management of events in a social system. “Good governance” in global health requires institutions capable of effectively delivering health goods, and mechanisms of participation and accountability that maximize the extent to which stakeholders at all levels can shape both the ends and the means of health programs.

The OSI Seminar on the Global Governance of Health brought together 40 global thinkers and leaders in public health, health services delivery, health policy, and academia for two days of intensive discussion of the current state of health governance, followed by two days of collaborative brainstorming on new initiatives in governance practice, research and theory.

Over the course of the Seminar, this group of prominent practitioners and theoreticians agreed that governance was important, timely, and unduly neglected in health. Ranging in scope from the city to global levels, presentations and comments laid out a complex picture of how governance deficiencies limit the impact of efforts to promote a higher level and fairer distribution of good health around the world. There was wide agreement that most of the pivotal issues—including inefficient resource allocation, corruption, top-down program design, lack of coordination, and insufficient involvement of civil society—could profitably be conceptualized as failures of governance. Despite this agreement, attendees had much difficulty arriving at a consensus on what terms or indicators to use to conceptualize these governance failures and what efforts are needed to remedy them. This struggle paved the way to constructive ideas about the necessary next steps for an initiative to improve the global governance of health.

Five themes emerged from these proceedings:

- This is a time of opportunity for meaningful change in the governance of global health programs.
- The governance of health at the global level is weak and coordination is poor.
- Participatory rhetoric from powerful actors has fallen short of giving stakeholders and civil society a meaningful role in decision-making.
- Despite the rise in funding and interest in disease-specific programs, the core mission of promoting population health and improving health systems is being obscured.
- Major empirical and political work is needed to improve the governance of global health programs.

Participants suggested a comprehensive, well-coordinated program of action in which health leaders, practitioners, researchers and civil society stakeholders would:

1. Design and implement strategies to mobilize global health leaders to improve governance internally—in their own organizations—as well as the system on the whole;
2. Develop strategies and build coalitions for boosting support among global elites for stronger public health institutions and global governance architecture built on a properly funded “anchor” institution;
3. Provide functional mechanisms of representation and organization of civil society in global health architecture, including support for civil society at the local level to participate effectively, continued human rights advocacy, and re-thinking current frameworks (such as the Global Fund’s CCM) from a governance standpoint;
4. Conduct interdisciplinary research to advance systematic measurement of governance, and identify or develop models of good health governance at the local, national and international levels.

www.healthgov.net
Introduction: A Time of Change and Opportunity

Global public health is in a time of change. It is not just the emergence of new health threats, like SARS and avian influenza, or the important new efforts being mounted against more familiar conditions like HIV/AIDS or the leading non-communicable killers like cancer and hypertension. We are also seeing a dramatic transformation in how the efforts to promote health are organized and run. We are seeing, that is, significant changes in the governance of public health at the global, national and even local levels. Important new funders, like the Bill and Melinda Gates Foundation, are driving the agenda. New mechanisms for funding, like the Global Fund to Fight HIV, TB and Malaria, have changed how decisions are made and priorities are set, and have tried to promote more civil society involvement in health policy. The World Bank, which once saw health as largely outside its brief, has in recent years taken on a role that sometimes rivals that of the World Health Organization. With the TRIPS treaty on intellectual property, the arcane workings of the World Trade Organization have suddenly been recognized as enormously important factors in global access to the fruits of biomedical research.

These changes in how policy decisions are made, and who makes them, reflect broader changes in global governance. Nations no longer enjoy a monopoly on governance, and themselves are often governed by non-state actors. Corporations, professions, NGOs and other institutions of civil society are orchestrating the course of events in health as in other areas. The players are changing, but the rules that make governance a fair game are not necessarily keeping pace.

Governance arrangements are at the heart of accountability between institutions and those they serve. New modes of governance can increase effectiveness and bring new stakeholders to the table – but they can also serve the ends of the powerful vested interests in the best position to game the rules. In the case of international public health and new global initiatives, governance will determine the long chain of accountability between a person in need of medicine and pharmaceutical makers setting prices or donors providing funds. Many well-informed people believe that the current system of governance has become chaotic and confusing to countries and civil society. This confusion undermines democratic decision-making about fundamental questions of life and death, and leads to inefficient use of public and private resources. Spending on global health has grown enormously, but may not be sustainable or of benefit to those in

\[\text{Governance is not synonymous with government. Both refer to purposive behaviour, to goal oriented activities, to systems of rule; but government suggests activities that are backed by formal authority whereas governance refers to activities backed by shared goals that may or may not derive from legal and formally prescribed responsibilities and that do not necessarily rely on police powers to overcome defiance and attain compliance.} - Rosenau J.N. (1995)\]


www.healthgov.net
greatest need. A plethora of donor-demanded coordination mechanisms may achieve specific goals but at the same time weaken capacity in health and health governance overall. It is urgent to rethink governance arrangements both to improve performance and to create new global models and norms of participation in a globalizing environment.

The December 2005 OSI Seminar on the Governance of Health was organized on the premise that both the need and the chances for global health governance reform are great. International policy dialogue is needed to mobilize greater resources for global health, improve resource management and program implementation, and bring about greater functionality, alignment, democracy and accountability in the institutions responsible for global health governance. Pursuant to the mission of the Open Society Institute, the focus on governance was meant to infuse the discussion of health with an equally vital concern for human rights, democratic decision-making and vigorous civil society participation.

The Seminar brought together 40 global thinkers and leaders in health services delivery, health policy, and academia for two days of organized discussion of the current state of health governance, followed by two days of group brainstorming on new initiatives in governance practice, research and theory. Participants were also invited to contribute to an on-line blog www.healthgov.blogspot.com, which served as a parallel virtual forum for the meeting. The Network Public Health Program Open Society Institute worked in partnership with Temple University Beasley School of Law and Yale University School of Medicine's Division of Global Health to convene this event.

The meeting had two specific tasks:

- To define, broadly, the state of health governance, drawing upon a multi-sectoral and multi-disciplinary perspective beyond health (e.g. law, political science, international relations) and bringing together public health leaders active in governance of public health; and
- To offer ideas for moving towards new governance strategies for health, deploying new norms, processes and institutions appropriate to governance practices today.

Governance:
- "The manner in which power is exercised in the management of a country's economic and social resources for development"
  -- World Bank

Seven “Methods of Power” in Global Governance:
1. Concentrate nodally the power under your direct control;
2. Have a big stick and threaten to use it;
3. Have a responsive regulatory strategy;
4. Network governance;
5. Be creative and assertive at nodes of networked governance;
6. Concentrate technical competence at nodes;
7. Shift forums when the forum gives the wrong result.

The Fruits of the Discussion

Over the course of the Seminar, the group of prominent practitioners and theoreticians who had assembled to discuss the topic of governance of health agreed that the governance of health was important, timely, and unduly neglected. Ranging in scope from the city to global levels, presentations and comments laid out a complex picture of factors that limit the impact of efforts in the realm of international health. There was wide agreement that most of the pivotal issues—including inefficient resource allocation, corruption, top-down program design, lack of coordination, and insufficient civil society influence—should be conceptualized as failures of governance. Despite this agreement, attendees had much difficulty arriving at a consensus on what terms or indicators to use to conceptualize these governance failures and what efforts are needed to remedy them. This struggle paved the way to constructive ideas about the necessary next steps for an initiative to improve the global governance of health.

Five main themes emerged from the discussions:

1. **This is a time of opportunity for meaningful change in the governance of global health programs.**

2. **The governance of health at the global level is weak and coordination is poor.**

3. **Participatory rhetoric from powerful actors has fallen short of giving stakeholders and civil society a meaningful role in decision-making.**

4. **Despite the rise in funding and interest in fighting particular diseases such as HIV/AIDS, the core mission of promoting population health and improving health systems is being obscured.**

5. **Major empirical work and political consensus-building is needed to improve the governance of global health programs.**

In the pages that follow, we describe the framework in which the discussion unfolded, and elaborate on the themes and recommendations emerging from the discussion.
Global Health Governance: Framing the Discussion

“Governance” is a term of increasing importance in many fields, and not surprisingly has been defined in many different ways. (See Boxes.) Governance – what it means and how it works – was addressed in a series of framework papers commissioned for the meeting.

Michael Kempa, Scott Burris and Clifford Shearing reviewed the rich literature on governance. They defined “governance" for this purpose as “organized efforts to manage the course of events in a social system.” “Governance,” they wrote, “is about how people exercise power to achieve the ends they desire.” But governance is not just about the technologies for exercising power; it concerns the ends of power as well. “‘Good governance’ in the abstract is governance that is good at delivering results (i.e., is efficient and effective) and that delivers results that are deemed good (e.g., fair, health-promoting).” The authors stressed three structural elements in governance:

- **Institutions**: organizational sites where governing resources are gathered and mobilized (government agencies, corporations, foundations, NGOs, criminal gangs).
- **Tools of influence**: methods or technologies that governors use to project influence (money, military force, claims of legitimate right to rule).
- **Constraints** on governors: limitations on the freedom of action of governors that may arise from laws (like a constitution or treaty) or competition from other governors (as in a market) or from culture (social norms).

These elements, in turn, define three ways that the practice of governance can be said to change:

- **Shifts in the locus of governing control**. Governance is said to be changing when there is an apparent shift of the locus of control from some governors to others.
- **Changes in the methods of power**. Governance can change when governors find new ways to project power towards other governors and individuals in the system.
- **Changes in the nature or effectiveness of constraints on governors**. Some writers on governance have observed changes in the nature or potency of constraints on governors.

The review uncovered wide agreement that these are times of profound governance transformation. We have moved from governance dominated by states (a “Westphalian” regime) to a world of governance better described as polycentric, with multiple agencies and sites of governance who govern through a variety of forms of power and largely in their own interests with far reaching collective impacts. “Much of the impetus behind the current interest in governance seems to be a sense that the normative goals that once animated a state-centered account of governance – stability, accountability, transparency, efficiency – are no longer being achieved, making it important to consider whether other theoretical descriptions of governance might guide us towards governance practices that do better.”

[www.healthgov.net](http://www.healthgov.net)
The authors distinguished two main reactions to the failure of old methods: "reinvention of government" and "reinvention of governance."

“Reinventing government” involves efforts to recalibrate state structures to improve their capacity to exercise centralized control of diffuse systems, often somewhat paradoxically by ceding much of the implementation of policy to non-state actors through devices like self-regulation and governance partnerships. “Reinventing governance” differs in that it takes innovation beyond the state and public-private partnerships into efforts to mobilize governors who may act with little or no connection with the state.

Efforts to reinvent government have had some signal successes, but strategies of deregulation and public-private partnership have not been panaceas. “Partnership structures have not proven immune to gaming or capture by those whose behavior the partnership was intended to constrain. The representativeness of partnerships, with and without formal community representation components, has been questioned, both on the ground that the citizen representatives are not given real control, and that citizens in representative positions are not actually representing or accountable to their communities. Neo-liberal governance strategies have more clearly benefited the wealthy and strong than the poor and weak.”

“Reinventing governance,” by contrast, “involves efforts to imagine new institutional forms and governance processes that overcome the problems that cling to traditional state-centered governance methods.” Innovators in this approach “seek to identify or invent institutions and practices of governance that do not depend upon the state and that mobilize knowledge, capacity and resources that have not been directed into governance before.” While there are some overlapping strategies, the authors write that the “key distinction between reinventing government and reinventing governance seems to be the ceding of true control to non-state actors.”

Wolfgang Hein, Sonja Bartsch and and Lars Kohlmorgen from the Global Health Governance group at the German Institute for Global and Area Studies presented findings from their analysis of institutional changes in the global governance of HIV/AIDS. They examined actors at global level (Global Fund, WHO, World Bank, UNAIDS and WTO) and at national level (with case studies on South Africa and Brazil) and analyzed their interactions.

Whereas Kempa, Burris and Shearing examined institutions, mentalities and technologies, Hein and his colleagues took an “actor-centered” institutionalist approach focusing on the interfaces between actors from different levels and institutions of governance. They distinguished between discoursive-programmatic, organizational, legal, and resource-based interfaces and argued that politics at these interfaces depended both on the respective institutional setting and the specific constellation of actors. With regard to the latter especially two aspects have to be taken into account:

**Clinical Governance**: "a framework through which organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" - UK (1998)
The different types of power actors exercise:

- decision-making power (ability to be involved in decision-making and in norm-setting),
- resource-based power (disposal over material resources and immaterial resources), and
- discursive power (ability to frame and influence discourses).

And the different types of interests they pursue:

- complementary interests—interests that are synergistic,
- conflictive interests—interests that are antagonistic,
- common interests—interests that are parallel,
- indifference.

Kohlmorgen’s paper assessed the work of UNAIDS, the World Bank and the WHO from this governance perspective. His assessment is mixed. “On the one hand, [global health governance] entails the inclusion and participation of non-state actors, NGOs, groups of PLWHA and local organizations, which might lead to political processes that are closer to the needs of the affected and ...increase the legitimacy of global health politics. National elites in developing countries and also elites in the North are put under pressure to enhance the fight against HIV/AIDS. Moreover, it presents the opportunity to pool available resources and knowledge...The governance structure with forms of hybrid regulation promises to be more flexible than state-based regulation .The effectiveness of governance and thus the output legitimacy may increase. On the other hand, we face a fragmentation of activities that leads to ineffectiveness. Due to the involvement of non-state actors, ... many governance processes are not legitimized. ... New forms of governance undermine the formal and ... democratically legitimized international organizations and the coordinating capacity of governments in developing countries.”

Sonja Bartsch presented a case study of the Global Fund to Fight AIDS, TB and Malaria. The Fund is the leading financing mechanism for TB and Malaria, and contributes to 20% of all international funding for HIV/AIDS. She stressed its importance as an example of new governance in health: “By choosing the approach of a public-private partnership and integrating non-state actors in decision-making process at the global and national level, the [Global Fund] represents a new way of doing business in the field of development cooperation that goes beyond a state-centered intergovernmental approach of other actors in global health governance like WHO or the World Bank.” Associated with the partnership model is a degree of transparency and openness that can be considered exceptional in comparison to many other international
institutions. Her assessment of the Fund’s own “raise it, spend it, prove it” mission found both success and challenges ahead, including resource mobilization, sustainability, demonstrating that its principles (performance-based approach, country ownership) are really making a difference, and improving its cooperation with other global health institutions. Additionally the Global Fund “must ... handle one problem that is typical for public-private partnerships: the existing tensions between a vertical approach in fighting specific diseases and broader horizontal approaches in health system development and promotion of public health.”

Through their research, the Global Health Governance group has described a number of processes and interfaces that have emerged in the course of the last two decades through activities of the World Bank, the WHO, UNAIDS, and others in the fight against HIV/AIDS. Their observations underscore the difficulty in applying traditional categories to the heterogeneous collection of actors now involved in international health and poverty reduction programs. Lack of coordination, geo-political squabbles, and dysfunctional governance frameworks were seen as the cause for lack of clarity and impact of certain organizations and duplication of effort, such as in the work of UNAIDS vis a vis WHO.

The last background paper, prepared by Derek Yach with Farnoosh Hashemian, focused on the need for the World Health Organization to “re-enter the global health arena” as a centralizing and stabilizing mechanism for evolving global governance networks in health. No other organization, they contended, is in a position to provide expertise, technical assistance and policy coordination across the full range of global health concerns. They called for strengthening the WHO, with particular attention to three crucial activities:

- Mediating the problematic intersection of trade and health. “One example of such efforts would be the currently in-progress Kyoto-style medical treaty, which encourages countries who sign on, to invest a percentage of their gross domestic product in medical innovation and enables countries to trade credits with other countries for investments in a manner similar to that designated in the Kyoto protocol to control environmental emissions.”
- Coordinating the health-related activities of the many international organizations whose work has implications for health but that for the most part do not have a health mission. “In this case the international health field can learn from international experience in lawmaking in biotechnology (e.g. the adoption of conflicting legal standards on intellectual property by organizations with overlapping legal jurisdictions) and the international environmental arena in which the gap in an overarching agency has lead to ‘counterproductive and inconsistent results.’”
- Continuing to reform and update global regulations for disease control. “Such work is consistent with a general consensus that improving global health in the twenty-first century will require multilateral coordination and cooperation among states through both international legal and non-legal instruments and with a major role for WHO as convener and coordinator and channel for codifying future health laws.”

Full text of the Background Papers, streaming audio of the presentations, and a list and biographies of the participants are available on www.healthgov.net.
Main Themes

1. This is a time of opportunity for meaningful change in the governance of global health programs.  

The Westphalian model, which deems the nation-state as the central feature of government, no longer adequately captures today’s governance landscape. Industrialized states remain powerful, but the advent of public-private partnerships and the increasing power of non-state actors like multi-national corporations and NGOs has changed the fundamental schemes of decision-making and service delivery in health and elsewhere. With change comes opportunity, the opportunity to build consensus for a new architecture for global public health.

Again and again, participants returned to the lack of coordination in global health efforts, and the need to find a “lead” agency. Some participants doubted that the WHO could play this role. After all, many of the changes in health governance, particularly the rise of public-private partnerships and the increase in bilateral health programs like PEPFAR, have been explained in terms of member-state dissatisfaction with the WHO. But in his presentation, Professor David Fidler pointed out that obituaries for the WHO may be premature. The new International Health Regulations entail an unprecedented increase in the formal authority of the organization, and recent epidemics of SARS and bird flu have reminded states of the unique advantage of WHO’s planning and enforcement capabilities. It is possible to use the new IHR regulatory mechanisms to promote human rights. Alex Capron pointed to the case of international regulation of human subject research as one promising example where civil society has been able to use new norms and regulations to promote human rights in health.

But there are a several challenges.

2. The governance of health programs at the global level is weak.

Good governance” in global health must solve three problems:

- Effective “horizontal” mobilization and coordinating of resources for health at the global level
- Effective implementation of health strategies downward from the global to the local
- Meaningful democratic participation in decision-making flowing upward from the local to the global levels.

“The public health community wants public health to be more central without taking politics into account. Governments cannot assert importance of public health without making pragmatic arguments; framing public health in terms of security and economic development would change the public health enterprise.”

–David Fidler
To do this, the system of governance must have institutions and mechanisms of coordination that promote rational and effective use of resources. It must be populated by institutions capable of effectively delivering health in a democratic way. Democracy in health requires, in turn, workable mechanisms of civil society participation, accountability indicators, and constraining or negative-feedback mechanisms to balance power. None of these features can emerge in the absence of political will and social norms supporting human rights and democratic health governance.

Global health governance is not presently satisfying these criteria. Coordination of efforts in health is poor. At the time when there are more players than ever before, there is a lack of planning and no central institution that can regulate, coordinate, and rationalize their activities. Norms of transparency and accountability do not necessarily apply to important actors like foundations and corporations. “Health for all” remains a distant goal.

Maria Ivanova made a valuable comparison of the Global Environmental Facility to the Global Fund and other financing mechanisms for health. She emphasized the commonality of challenges across the two areas of health and environment, and the advantages of further comparative analysis to finding governance solutions. From the environmental field, she suggested the need for an “anchor institution” in health. An Anchor Institution is a body that can provide a vision and serve as the principal interface for all global health efforts. Such an institution can also act as a source of standards, rules, and monitoring schemes to promote transparency, accountability, and participation. If correctly designed, such an institution holds the promise to reduce the duplication of effort and provide a foundation for synergy among the various actors now involved in provision of health services across the globe. There was much discussion of whether the WHO acts or could act as such an anchor institution. This is the natural role of the WHO, but the consensus was that the WHO is not fulfilling that role today.

The World Bank has the resources, but neither the commitment nor the breadth of expertise to be the world’s anchor institution in health.

---

The World Bank's power comes from the money, and WHO doesn't have the same power.
--Obi Aginam

www.healthgov.net
The question of the anchor institution is just one facet of the need to revise the “architecture” of global health governance. Individual global institutions and organization have limited ability to identify and repair their governance problems. Sunsetting institutions that no longer serve a useful purpose is difficult. Few existing evaluation mechanisms or practical tools are available to provide accurate feedback for what needs to be fixed and how. NGOs and developing states have been able to use policy and media advocacy to affect change, as with human rights issues and human subjects research, but even good intentions are usually not translated into reality.

Transparency and accountability have been recognized as imperatives, but are difficult to assess and are rarely achieved. Corruption and ineffective use of resources is widespread. As Maria Ivanova noted in her presentation, the imbalance in the distribution of funds between national and various global health and environmental agencies is striking for their implications as to capacity. While national governments certainly have a responsibility to provide environmental public goods, the global nature of environmental challenges requires sufficient investment in developing country and international capacity, not least in the area of governance.

3. Participatory rhetoric from powerful actors has fallen short of giving stakeholders a meaningful role in decision-making.

Good governance and effective implementation require that recipient nations, civil society and the communities meant to benefit from global health programs have the opportunity and the capacity to meaningfully participate in setting priorities, working out implementation methods and holding providers and funders responsible for results. Despite real attention to this issue, global health programs have not avoided the problems of implementation common to other international aid programs.
The problems are many. Accurate assessments of needs and the local knowledge that is necessary for effective implementation are all downstream, while most real decisions are made far upstream.

Communication mechanisms that would allow downstream actors to shape programs are not functional. Agenda/priority setting, program design, and program implementation in global health are all defined by the powerful actors—governmental and non-governmental entities in the industrialized world—who often use health as a vehicle to pursue their economic, political, or foreign policy agendas. Local, regional and national voices from those communities on the receiving end of services are largely absent from the decision-making and architecture process (including, it was pointed out, this Seminar itself).

Actual implementation of health programs suffers from corruption, lack of capable staff or poor transparency and accountability. There is a real lack of capacity-building and funding for civil society participation: There is often talk about involving NGOs and stakeholders in governance but the investment that would make such participation a possibility is rarely made. Even when earnest attempts are made to address these issues at the global level, they stubbornly persist at the local level. Country-level activists on AIDS at the meeting decried the way the Global Fund CCM worked as a mere proxy for community representation. Weaker states in South often see health as a lower priority, choosing to use their limited governance resources in other areas. Even where health is seen as a priority, resources limit the ability of both civil society and developing country governments to project power in global networks.

International initiatives also may harm national efforts by siphoning off talent from other areas of health or social work. Strong will and ability to regulate at the national level is important for effective public health efforts and may be good for protection of human rights. It is always necessary to strike a balance between state police powers and human rights.

4. Despite the increase in funding and interest in fighting particular diseases such as HIV/AIDS, the core mission of promoting population health and improving health systems is being obscured.

The new global partnerships, in spite of impressive gains, are not a panacea. Coverage of HIV anti-retrovirals, for example, remains too low. (See Box.) And in spite of the many new entrants...
into the field, a range of problems from neglected diseases to the continuing medical brain-drain from developing to developed countries remain governance “orphans.”

---

### Estimates ARV Coverage in Developing Countries

<table>
<thead>
<tr>
<th>Region</th>
<th>UNAIDS/WHO estimates</th>
<th>Treatment coverage in June 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>People needing</td>
<td>People receiving</td>
</tr>
<tr>
<td></td>
<td>treatment in 2005</td>
<td>treatment in June 2005</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>500,000</td>
<td>4,700,000</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>290,000</td>
<td>465,000</td>
</tr>
<tr>
<td>East, South and South-East Asia</td>
<td>155,000</td>
<td>1,100,000</td>
</tr>
<tr>
<td>Europe and Central Asia</td>
<td>20,000</td>
<td>160,000</td>
</tr>
<tr>
<td>North Africa and the Middle East</td>
<td>4,000</td>
<td>75,000</td>
</tr>
<tr>
<td>All developing and transitional countries</td>
<td>970,000</td>
<td>6,500,000</td>
</tr>
</tbody>
</table>

---

Again and again, the discussion turned from the governance of health to its mission. What, participants, asked, are we governing health towards? A number of participants were concerned about the implications of the fact that so many new health programs and partnerships were of the “categorical” variety – aimed at a particular disease or condition. This seemed to them a further, and undesirable, departure from the Alma Ata vision of “Health for All” that animated the work of the WHO in the last quarter of the 20th century. Others more particularly lamented the neglect of the non-communicable diseases responsible for the bulk of morbidity and mortality in the world. The dominance of categorical programs and investment aimed at particular communicable diseases highlights the continuing neglect of the chronic diseases that account for the majority of global deaths.

Participants were also warned of the risk that raising money through categorical programs is a “Faustian Bargain,” in the words of Gene Matthews. There is money for categorical missions, but in the long run, discrete programs produce limited gains and can weaken core capacity for generalized health protection and promotion.”

Some also chaffed against the narrow focus on health programs. Any examination of health governance must consider wider governance processes that shape structural factors influencing health. The outlook has to account for economic, environmental,

---

My big discomfort is how we look at health: from disease and prevention perspective rather than the health as a resource, to be promoted and produced in greater amounts and better distribution. - Susan Mercado

---

Is health to be governed with reference to promoting the fundamental and structural determinants of health, or in terms of solving particular health problems like AIDS or tobacco use? -Scott Burris

---

http://www.avert.org/aidsdrugs.htm

---

www.healthgov.net
human rights, civil society, and technological governance on the global level. Health and economics and health and human rights are especially tightly related, and must be considered in concert. Health must be promoted as a general societal asset, key to economic, social, and other development. Ultimately, health governance is global governance.

5. **Major empirical work and political consensus-building is needed to improve the governance of global health programs.**

Governance is changing, but the classic questions about governance remain. What institutions are governing, and how effectively? Through what processes are decisions made and implemented? What norms are guiding and constraining these institutions and the processes they use? The more practitioners, funders, and theoreticians identify poor governance as the cause of serious problems that limit the impact of efforts to improve health, the more they underscore the dearth of knowledge and practical tools to help identify, describe, and address governance success and failures.

What we need from global governance is equitable procedures and effective results. How do you design this? It is necessary to conduct a comprehensive analysis of the global governance. Without examining where we are how, how we got here, and where we want to go, little progress can be made. - Maria Ivanova
For the Future: Next Steps for Global Governance of Health

In the final phase of the meeting, participants divided into working groups to suggest ideas for next steps in the long-term exploration and reform of health governance. These suggestions span the governance landscape from the local to the global, and embrace methods as diverse as NGO capacity-building to “Delphi” projects among the global health leadership elite. As the product of brainstorming and free discussion, they are not formal recommendations but suggestions for instigating a coordinated and broadly-supported effort by global health governors and stakeholders themselves to improve governance. The outcomes presented below offer a set of ambitious ideas that will require significant buy-in from leading actors in the health field, including the governments of key states and major funders. Anything less will fall far short of tackling the complex and all-pervasive issue that is global governance of health. Participants’ suggestions may be organized broadly into four kinds of strategies:

1. Strategies to develop a new architecture of global health governance.

There is widespread dissatisfaction among public health leaders with health governance today, but it can be difficult for practitioners to escape the pressure of solving immediate problems within the existing framework. The urgent question is not, for example, what should happen to the Global Fund or GAVI this year, but which organizations will still be in place and how they will be managed five years from now. A variety of techniques can be used to bring health leaders together to think about governance and to envision an effective, practical and rational distribution of organization and responsibilities. Potentially useful approaches include convening leaders in public health through a Delphi consensus-finding survey, Bellagio meetings, or executive sessions (an approach developed at the Kennedy School that teams leaders and academics to collaborate on policy innovations over a period of 12 to 18 months). It would also be useful to look across from health to other sectors such as environment and education, to compare governance successes and failure. It will be important, too, to include in these visioning processes people who work at the national and local levels. A significant part of the governance problem across the range of global aid programs is the lack of input from and accountability to the recipients of aid, including civil society representatives. All of these efforts will require academic support from researchers preparing background documents and following up on ideas generated.

2. Strategies to influence U.S. policy in the direction of supporting strong international public health institutions.

Designing a new architecture of global health governance without U.S. support is doomed to failure. The conventional wisdom, particularly among international relations specialists, is that the U.S. opposes strong international institutions, in health as in other areas, but a compelling case can be made that, in an era of increasing concern about the globalization of
disease and bioterrorism, the U.S. will see the need for strong global governance institutions in health.

Building U.S. support will require targeting key U.S. policy-actors outside of health, including congressional staffers; think-tanks such as Woodrow Wilson Center, the Council on Foreign Relations and Brookings; and making the case at important venues like the World Economic Forum in Davos.

3. Strategies to build health governance capacity at the national and local levels, with particular attention to the needs of civil society stakeholders.

Governance doesn’t just fail because of global-level constraints, but also because of defects in the design of the interfaces between the global, national and the local. Country Coordinating Mechanisms (CCMs), National AIDS Councils (NACs), and Project Implementation Units (PIUs) are examples of governance mechanisms designed at and imposed from the top that have too often failed because they build on existing institutional arrangements. Rather than try to create new institutions, it is usually better to build out from existing institutions, and this requires context-specific innovations, not generic global solutions. Governance design needs to become a distinct part of program development, one that is properly funded and carried out in cooperation with and deference to aid recipients. Approaches mentioned at the Seminar included an independent “Health Governance Facility” (a mechanism that would support the development of effective governance mechanisms for new programs), the requirement of a multi-lateral “governance development phase” in the roll-out of new programs, and systematic research to support innovation and effectiveness in local governance. In any event, it is clear from decades of experience that one size does not fit all, and that governance needs to be in the forefront of consideration in program design, not an afterthought. A health governance facility would generate a set of governance principles, train a cadre of “health governance experts,” provide training and support to governance arrangements, and generate information on best practice. It will also be useful to convene a series of meetings, or an executive session, bringing together people doing health work and people in the broader development field who have focused on community building and governance (“community driven development” or “social development” programs). A prime object of all these activities should be the better integration of civil society in democratic health governance practices.

The New International Health Regulations integrate four key government policies: security, economic activity and wellbeing, development, and protection of human dignity. Public health thus becomes an integrated public good. But these strategies are reactive, rather than proactive. The big question is how does the WHO achieve positive health externalities out of this?

-- David Fidler

www.healthgov.net
4. Strategies to learn how to measure governance success and failure and identify best practices for effective health governance.

The development of innovative governance approaches in health is a real challenge. A strong component of responsive academic research is needed to fulfill each of the strategies described above. For example, many participants argued for the need to develop indicators for health governance that were more specific than the current broad-based indicators of governance. Given the context-specific nature of governance, which is path dependent, and determined by the existing set of institutional arrangements, it is important to develop a broad approach to monitoring and evaluation of governance arrangements to generate new theories about what governance is and how it can be organized; and new visions of institutional design and management. Another suggestion was research project devoted to identifying and understanding the “design elements” of successful forms of local governance. Ideally, academic researchers will work in collaboration with practitioners and stakeholders in synergistic, action research.
Conclusion

“Good governance” in global health has two related characteristics: institutions capable of effectively delivering health goods, and mechanisms of participation and accountability that maximize the extent to which stakeholders at all levels can shape both the ends and the means of health programs. Participation and accountability are important not just as democratic goods in themselves, but as essential means of building support for health and capacity to implement health initiatives.

While some participants took a dim view of the prospects for strengthening global health institutions, David Fidler and others argued convincingly that we may be in a time of opportunity when the US and other major players can be convinced of the value of a strong WHO and the need to align health governance accordingly. A more robust governance infrastructure with an anchor institution in the middle holds real potential to promote human rights and development of civil society. Moreover, there was wide consensus that governance was often simply neglected in global health and that focusing attention and capacity building on governance could lead to meaningful improvements both in how programs are organized at the global level and how they are administered downstream.

At the same time, the participants who work at the national level were united on their criticism of the governance and implementation of global health programs at the national and local levels. This was true even with a relatively governance-sensitive entity like the Global Fund and even for such a high-capacity-civil-society country as South Africa. It was observed that many of the dysfunctional practices in implementation and governance are predictable consequences of the global political factors that shape the development of health priorities, health funding and health institutions. Naturally, too, people who work at the global level do not see the world in the same way as those who work at the national or local level, and so may not always be able to escape the pull of their own biases and experiences. It follows that global institutions have limits on their ability to identify and repair their governance problems. Efforts to repair global governance must therefore also involve work at the national and local level to increase the capacity of downstream actors to “push back” against the dysfunctional practices of global actors, and the capacity of downstream actors to mobilize their own resources and to better cope with upstream problems. Hence the suggestions that follow, while divided between the upstream and downstream actors, should be seen as a coordinated whole.

At a time of major change and important opportunity, governance is not well understood. Though both practitioners and theoreticians acknowledge its pivotal role, they contend that they know little about how to improve its functioning. Coordinated efforts should be taken to build a knowledge base about the fundamental mechanisms of governance and examples of best practices in governance of health.
Appendix 1: Seminar Participants

**Obijiofor Aginam**  
Professor of International Law, Department of Law, Carleton University  
Ottawa, Canada

**Sam Avrett**  
Consultant, Open Society Institute Public Health Program  
New York, U.S.

**Francoise Barten**  
Coordinator, Nijmegen Urban Health Group  
Nijmegen Radboud University  
Nijmegen, The Netherlands

**Sonja Bartsch**  
Research Fellow, German Overseas Institute,  
Hamburg, Germany

**Leo Beletsky**  
Senior Associate, Temple University Beasley School of Law  
Philadelphia, U.S.

**Carla Boeckman**  
Associate Director, Centre for Strategic Insight, World Economic Forum  
Geneva, Switzerland

**Michael Borowitz**  
Director, Open Society Institute Public Health Program  
New York, U.S.

**Scott Burris**  
James E. Beasley Professor, Temple University Beasley School of Law  
Philadelphia, U.S.

**Alex Capron**  
Director, Department of Ethics, Trade, Human Rights, and Health Law, World Health Organization  
Geneva, Switzerland

**Jonathan Cohen**  
Director, Open Society Institute Health and Law Program  
New York, U.S.
David Fidler
Professor of Law and Harry T. Ice Faculty Fellow, Indiana University School of Law
Bloomington, U.S.

Wan Yan Hai
Director, Beijing Aizhixing Institute of Health Education
Beijing, China

Farnoosh Hashemian
Research Associate
Department of Global Health
Yale School of Public Health

Judith Healy
Senior Research Fellow, Regulatory Institutions Network, Australian National University
Canberra, Australia

Wolfgang Hein
Professor of Political Science, University of Hamburg, Head of Research Unit on Transformations in the Process of Globalization, German Overseas Institute, Hamburg

Mark Heywood
Head of the AIDS Law Project, University of the Witwatersrand
Johannesburg, South Africa

Maria Ivanova
Assistant Professor, Department of Government, The College of William & Mary Williamsburg, U.S.

Jorge Jimenez de la Jara
Professor of Public Health, Pontificia Universidad Catolica de Chile
Santiago, Chile

Michael Kempa
Assistant Professor, Department of Criminology, University of Ottawa
Ottawa, Canada

Lars Kohlsmorgen
Research Fellow, German Overseas Institute,
Hamburg, Germany

David Legge
Associate Professor, School of Public Health, LaTrobe University
Melbourne, Australia

www.healthgov.net
Maureen Lewis
Senior Fellow, Center for Global Development
Washington, U.S.

Vivian Lin
Professor of Public Health, School of Public Health, Latrobe University
Melbourne, Australia

Ellen Liu
Program Officer, Open Society Institute Public Health Program
New York, U.S.

Gene Matthews
Director, Institute of Public Health Law of the CDC Foundation
Senior Fellow, University of North Carolina School of Public Health, Chapel Hill
Atlanta, U.S.

Margaret McIntyre
Senior Associate Program Director, The Task Force for Child Survival and Development
Decatur, U.S.

Susan Mercado
Programme Coordinator, Cities and Health, WHO Centre for Health Development
Kobe, Japan

Scott Newton
Chair, Centre for Contemporary Central Asia and the Caucasus, SOAS, University of London
London, U.K.

Phillip Nieburg
HIV/AIDS Task Force, Center for Strategic and International Studies
Washington, U.S.

Alex Ross
Senior Advisor to the Assistant Director-General for HIV, TB and Malaria
World Health Organization
Geneva, Switzerland

Jennifer Prah Ruger
Co-Director, Assistant Professor, Global Health Division, Yale University School of Medicine
New Haven, U.S.

David Sanders
Professor and Director, School of Public Health, University of the Western Cape
Bellville, South Africa

www.healthgov.net
**Anthony So**  
Director, Program on Global Health and Technology Access, Duke University  
Durham, U.S.

**Sally Stansfield**  
Associate Director, Global Health Strategies, Bill and Melinda Gates Foundation  
Seattle, U.S.

**Ronald O. Valdiserri**  
Acting Director, National Center for HIV, STD, and TB Prevention, U.S. CDC  
Atlanta, U.S.

**Jeanette Vega**  
Office of the Assistant Director-General, World Health Organization  
Geneva, Switzerland

**Diana Weil**  
Sr. Policy Adviser, Stop TB Department, World Health Organization  
Geneva, Switzerland