

***Global Health Governance – A Search for Meaning***

Inaugural S.T. Lee Lecture

Menzies Centre for Health Policy, University of Sydney, 16 July 2009

Delivered by Dr Tikki Pang, Director, Research Policy & Cooperation, World Health Organisation

RESPONSE TO KEYNOTE PRESENTATION

***Global Health Governance: Asking Some Naïve Questions***

Roger Magnusson, Professor of Health Law & Governance, Sydney Law School

This evening's seminar is about "global health governance" but I have some doubts about this term.

Like the word "discourse", which also has no definite or necessary meaning, I think it's a term that tends to get thrown around when people aren't quite sure what they mean or what they want to say.

This is not a criticism that applies to Dr Pang, whose understanding of the challenge of global health is both comprehensive and finely nuanced. He also speaks with great honesty, as you've heard.

Part of the problem is that "global health governance" is a term that describes something that is very complex.

This evening Dr Pang has helped to unpack some of that complexity: to understand the multiple challenges to global health, while pointing to some of the possible solutions.

In fact, that's one of the reasons why "global health governance" is an ambiguous phrase. As Dr Pang has pointed out, it directs attention both to a complex problem, and to the challenge of "global problem solving".<sup>1</sup>

In the area of non-communicable disease, which is an area of interest of mine, the problems have been well documented.

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Think of the 35 million people who die each year from chronic disease, including 7.1 from high blood pressure, and 4.9 from tobacco. Much of this burden of disease is preventable, but putting the policies in place to achieve this is not easy.<sup>2</sup>

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Or think of the challenge of setting up effective primary health care systems in developing countries: building the infrastructure, effective financing, accountability systems, human resources, supply chains that work, pharmaceuticals at prices that people can afford.

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Or think of the risk of internationally contagious diseases, many of which arise from unhealthy environmental conditions, particularly from the co-location of humans and animals.

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<sup>1</sup> Devi Sridhar, Sanjeev Khagram, Tikki Pang, "Are Existing Governance Structures Equipped to Deal with Today's Global Health Challenges – Towards Systematic Coherence in Scaling Up" *Global Health Governance*, Vol II, No 2 (Fall 2008/Spring 2009) <http://www.ghgj.org> (at 1).

<sup>2</sup> WHO, *Preventing Chronic Disease: A Vital Investment* (2005).

Global health governance is difficult because fixing these problems is difficult. The uncertainty of the concept of global health governance mirrors the challenge of making progress across these and many other areas.

Global health governance is not just a concept: it's the challenge of developing better strategies

- to respond to **disease**,
- to respond to **health risks**, and
- to create the **conditions where people can live healthy lives**.

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For those who are interested, I would warmly recommend a paper written by Dr Pang and colleagues which reviews proposals and strategies for responding to the challenges of global health.

It is published, appropriately, in the journal *Global Health Governance*: Devi Sridhar, Sanjeev Khagram, Tikki Pang, "Are Existing Governance Structures Equipped to Deal with Today's Global Health Challenges – Towards Systematic Coherence in Scaling Up" *Global Health Governance*, Vol II, No 2 (Fall 2008/Spring 2009) <http://www.ghgi.org>.

What I would like to do for the next 10 minutes is to ask some naïve questions that might help us to peel back the layers of the complex challenge that is global health governance.

**[slide] - [Question: What is "global health governance"?)**

One way into the concept is through definition. What we acknowledge as the challenges of global health governance will be profoundly influenced by what we regard as the goals of public health.

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I see public health, both globally and nationally, as the pursuit of three main goals:

- **Firstly, population health:** by this I mean the goal of improving the *average health of the population* to the greatest extent possible;
- **Secondly, health inequalities:** responding to the particular needs of those who would get left behind if we focused only on average health;
- **And thirdly, we're increasingly realizing the goal of intergenerational health:** and this is where the link arises between *sustainability and health*: sustainable health systems, and environments that create conditions for sustainable healthy living.

One thing that you'll notice about the goals of global health is that they go well beyond clinical care and health systems. This is one of the reasons why global health governance – like public health at the national level – is a multidisciplinary enterprise. It responds to the global determinants of health and illness, not only to the clinical needs of sick populations.

And naturally enough, each discipline asks itself what it can contribute to global health improvement.

In the case of my own discipline, law – some would say that law can make you miserable. But can it make you healthy? And how feasible is a “legal fix”?

There are many other kinds of “fixes” as well: engineering fixes, agricultural fixes, economic and fiscal fixes, educational fixes, and urban planning fixes. But the unit of analysis is large. We're talking about “global” health governance: we're not just talking about what makes individuals healthy. And there is a profound difference in terms of policy content, depending on whether our focus is on individuals, countries, or whole regions – the global level.

One difference is that at the global level we must inevitably talk about systems: high-order strategies that encompass incentives and structure and architecture to do the things that will drill down, eventually, to make a difference at the country level.

**[slide] – [Question: What’s “global” about global health governance?]**

But that still doesn’t answer the question: what’s “global” about global health governance?

Or is global health nothing more than the sum of the national health problems of all countries?

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One reason we talk about global health is because the trans-national nature of the determinants of disease can create deficits in national health sovereignty.

To respond effectively to internationally contagious disease, or to global warming, or to nuclear proliferation requires international policies, not just domestic ones.

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In addition to this, global responses are needed to respond to the health consequences of globalization itself; for example, the trend towards non-communicable diseases that accompanies the dietary transition, urbanization, and the relentless marketing of global tobacco, food and beverage brands.

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In addition to trans-national determinants and globalization, many countries face resource constraints in financial, material, technical and human terms.

Associated with this, countries may lack the capacity (or political will) to prioritise and implement policies where needed. This is the whole point of development assistance in health, including technical assistance.

But so many countries are in this situation – and the populations at risk due to weak health systems and the absence of effective health policies are so large that a coordinated global response to the issue is necessary – because bilateral assistance from wealthy donor countries hasn't managed to solve the problem.

This is the implicit assumption behind the Millennium Development Goals.

Global health governance seeks to respond to intractable domestic health problems that have been neglected or which defy resolution at the country level.

To take another example that relates to chronic, non-communicable disease: with over 1.1 billion adults overweight,<sup>3</sup> the incidence of diabetes is expected to double from 171 million to 366 million cases over the period 2000-2030.<sup>4</sup> Already, 70% of the diabetes burden is borne by developing countries.<sup>5</sup>

Why else are “global” responses needed, as distinct from national responses, or traditional forms of bilateral development assistance?

Two more reasons worth mentioning are that coordinated global action can be necessary to enhance the effectiveness of the many global health stakeholders who work at the country level.

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<sup>3</sup> P. Hossain, B. Kavar, M. Nahas, “Obesity and Diabetes in the Developing World – A Growing Challenge,” *New England Journal of Medicine* 356, no. 3 (2007): 213-215.

<sup>4</sup> S. Wild, G. Roglic, A. Green, R. Sicree, H. King, “Global Prevalence of Diabetes: Estimates for the Year 2000 and Projections for 2030,” *Diabetes Care* 27, no. 5 (2004): 1047-1053.

<sup>5</sup> United Nations General Assembly, Resolution 61/225: “World Diabetes Day”, A/RES/61/225, 18 January 2007, at: [http://www.worlddiabetesday.org/files/docs/U4D/UNR\\_media\\_kit\\_0407.pdf](http://www.worlddiabetesday.org/files/docs/U4D/UNR_media_kit_0407.pdf) (accessed 1 July 2009).

This is the kind of thinking that explains the International Health Partnership, which attempts to put into practice the Paris Declaration on Aid Effectiveness.

The need to improve the effectiveness of funding provided to advance the MDGs has stimulated new partnerships including the 'International Health Partnership' signed in September 2007 by a coalition of donor and recipient countries, international agencies and other funders.<sup>53,54</sup> This partnership emphasizes the need for health development to be country led, to strengthen the whole health system, to permit greater flexibilities in use of funds, as well as 'shared appraisal, funding and reporting mechanisms'.<sup>53</sup> The International Health Partnership, in turn, represents one attempt to put into practice the Paris Declaration on aid effectiveness, a statement of principles having normative (albeit non-legal) force.<sup>55</sup> The International Health Partnership has since developed its own unique governance structure.

Finally, global processes can help us to identify, evaluate and disseminate best practice, reducing the gap between research and evidence-for-action, and the implementation of effective policies at the country level.

And this is important because much of the day-to-day work of development assistance agencies like the World Health Organisation and the World Bank consists of technical assistance for countries that are seeking advice on effective national policies.

**[slide] – [Question: Who “does” global health governance]**

Another question we might ask ourselves is: Who “does” global health governance?

It is sometimes said that the key characteristic of global health governance is the growing influence and strategic role of non-state actors, including INGOs, but particularly private foundations, and also the emergence of public/private partnerships.

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In 2008, for example, the Bloomberg Foundation pledged \$250 million over 4 years for implementing tobacco control programs in low and middle-income countries. The Bill and Melinda Gates Foundation pledged \$125 million over 5 years.

This kind of money is unprecedented in tobacco control, and not surprisingly, the “Who’s Who” of influential players in global health has changed accordingly.

In this more fluid environment, some new challenges are emerging.

For example, Dr Pang’s agency, the World Health Organisation, is having to think hard about where its role lies. It is not a taxing authority; it has limited resources, and it largely represents the interests of member states.

WHO has a very strong convening power, and has generated a high degree of trust and good will (it has a very strong “brand”); and yet the primary link to Health Ministries, rather than Finance Ministries, affects the nature of its influence. Increasingly, getting things done at the global level requires creative partnerships between stakeholders whose influence and resources are aligned to the issue at hand.

Another important question that is arising is how to partner effectively with the private sector. How do we create incentives for the development and effective distribution of pharmaceuticals to respond to neglected diseases, or to treat disease in populations that are impoverished and can’t afford to pay?

Or, to take another example: to what extent should health stakeholders partner with food industry, or will market incentives corrupt the capacity for innovation that the food industry might otherwise bring to diet-related disease?

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That brings me to my next question: How do things get done in global health? What are the various forms of governance?

In so far as the ultimate aim of global health governance is to see effective health systems and policies on the ground at the country level, I think there are three main pathways through which to achieve this.<sup>6</sup>

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**Firstly, partnerships and governance structures** (including targets and goals) can serve to focus political commitment and coordinated action towards health improvement. The engine driving work towards the Millennium Development Goals, for example, is the political commitment of UN agencies, the World Bank, and other stakeholders, to work together to achieve them.

**Secondly, treaties, guidelines and other normative standards** can also influence domestic policy change through normative pressure, and reporting requirements. Global standards can give rise to obligations owed by signatory states under public international law, but normative pressure to develop one's policies consistently with international standards does not always require a legal agreement.

**And thirdly, the direct provision of finance and material support, as well as the conditional provision of material support**, can also support programs and drive policy change and implementation.

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<sup>6</sup> See Roger Magnusson, "Rethinking Global Health Challenges: Towards a 'Global Compact' for Reducing the Burden of Chronic Disease" (2009) 123 *Public Health* 265-274; Roger Magnusson, "Non-communicable Diseases and Global Health Governance: Enhancing Global Processes to Improve Health Development", *Globalization and Health*, 2007, 3:2; available at: <http://www.globalizationandhealth.com/content/3/1/2>

**Nor should we forget informal pathways:** for example, advocacy by public health leaders – like Dr Pang- as well as the impact of popular movements in civil society and academia, and media campaigns mobilizing popular opinion.

**[slide] – [Question: Are there distinctively “global” public health functions?]**

I’d like to conclude now by asking one last naïve question. If the challenge of global health is more than just the sum of each country’s national problems, then are there some distinctively “global” health functions that can only be discharged through collective global action, and which can’t really be *fully discharged* at the national level?

I think the answer is yes. In fact, I would argue that global health governance involves recognizing and discharging these distinctively global responsibilities.

Among them are the need for global surveillance and analysis of burden of disease data. But in addition to this: the monitoring and evaluation of policy interventions. [WHO, and the World Bank, should in my view embrace more fully the role of “policy librarian” – sharing experience with the implementation of policies within member States].

At the global level, the public health protection and assurance function extends to sharing the evidence around best-practice interventions, including policy interventions. It includes the active promotion of international standards, recommendations, strategies and action plans.

Development assistance is an important way of ensuring continuity and security of funding for health services provision. But in addition, the health development environment is now so complex that it is important to identify gaps in funding, and areas where existing funding is warping research and service provision at the national level.

Distinctively “global” health functions extend further than this, but my time this evening does not.

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So here, then, are my five naïve questions about global health. Like Dr Pang, I certainly agree that we can’t improve the health status of the world – especially the developing world – if we remain trapped in a national mindset.

I agree that global health governance is transnational, multi-sectoral, and bridges both clinical care and health policy. And as Dr Pang’s slides illustrate, the institutional and governance environment is also extremely complex. In fact, Dr Pang’s presentation confirms for me that what we are witnessing is strong competition between existing institutions, and possible new structures, for influence and control over our collective response to the world’s most pressing health challenges. It is not at all clear which structures will take precedence in future.