

Are the 'Good Times' Over? Looking to the Future of Global Health Governance

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After ten years of unprecedented attention and funding for global health, and a simultaneous increase in the range and number of institutions involved in global health governance, we have arrived at what seems to be a watershed moment. This paper assesses the future of global health governance in this context. In particular, the financial crisis, the rise of middle-income powers, and changes in US domestic politics are all viewed as injecting new fault lines and dynamics into the existing system of governance. Although the impacts of these changes are likely to be profound, the paper argues that the private and hybrid public-private institutions that have become prominent in global health governance in the last decade will continue to play a central role in tackling a narrowly delineated range of global health problems, albeit with potentially fewer resources. Indeed the trend for a greater emphasis on 'private' forms of authority seems likely to become further entrenched by the financial crisis-engendered emphasis on the delivery of efficient global health interventions.

INTRODUCTION

Over the last decade we have witnessed a breathtaking transformation of global health governance. Most strikingly, we have seen both the generation of a whole new institutional architecture (a process which is still ongoing) and the foregrounding of health in international politics as never before. The emergence of Global Health Partnerships (GHPs) and 'mega' foundations as actors central to, and widely recognised as legitimate in, global health governance has been one of the most significant examples of change. Many of the institutions which are now at the very heart of responses to global health crises did not even exist fifteen years ago.¹ They have been both cause and consequence of the fact that the issues which they have been created to address have risen spectacularly in prominence, in some cases genuinely becoming matters of 'high politics'. While even as recently as the late-1990s it made sense to talk about today's 'big three' diseases (HIV/AIDS, malaria, and tuberculosis) as being 'neglected', they are now firmly in the consciousness of the global public and policy-makers alike, and have attracted substantial resources. Indeed, the question posed by many commentators today is whether the resources devoted to the 'big three' are disproportionately large, undermining responses to conditions and diseases which *are* still worthy of the 'neglected' label.²

In some ways, the last decade has been a good time for global health. It is certainly true that a massive expansion in spending has been at the heart of the transformation of global health governance. As was shown in a recent paper in *Health Policy and Planning*³, the level of resources being devoted to global health has risen substantially, even though the plurality of finance sources and the complexity of the global health governance 'system' make it difficult to track the figures precisely.⁴ What we do know for certain is that some diseases, most notably HIV and AIDS, have

attracted unprecedented resources. The results of this investment are now becoming apparent. The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) claims to save 3,600 lives each day.⁵ The number of people in low- and middle-income countries receiving antiretroviral therapy rose by 30 per cent to a total of 5.2 million people from December 2008 to December 2009.⁶ The recognition that there is still much more to be done, and that there are many health challenges which are not being addressed adequately, should not obscure the fact that in some areas there have been real improvements in global responses. Although inequalities in health remain pervasive, and despite legitimate misgivings about the targeting of resources, there is a widespread perception that over the last decade global health has enjoyed something of a heyday.⁷ It is the current widespread unease within global health communities that the 'good times' may be drawing to a close that this paper takes as its starting point.

In this paper, we examine the future of global health governance, arguing that we are currently witnessing significant economic and geopolitical changes which will have a dramatic impact on that 'system'. We begin by looking at the recent history of global health governance, and subject the idea that the 2000s were 'good times' to critical scrutiny. The paper then proceeds to assess the impact of a range of economic and geopolitical changes, and argues that they are already beginning to constrain the material resources and undermine the political dynamism that have driven the boom years in global health. The financial crisis in particular poses real challenges to the current system of global health governance, a challenge that will be further complicated by the ascendance of middle income countries, who bring some very different ideas to the table, and domestic political changes within the US.

However, in the final part of the paper we argue that, despite these challenges to the existing system, it is likely that the shift to private forms of authority which has characterised the last decade of global health will become further entrenched rather than scaled back, not least because developed states are seeking increased value for money and efficiency in their aid spending. This will impact upon GHPs, other global health actors, and states. For GHPs, while significant budget constraints will limit their ability to expand (or perhaps even maintain) their current level of operations, the basic model of health aid with which they have been so closely associated, and which they and their architects have promoted, will continue. It is unlikely, therefore, that their future viability or governance *modus* will be fundamentally threatened. Added to this, the major philanthropic foundations in global health, such as the Gates Foundation, appear relatively immune to the crisis as it has developed so far, and reductions in state-based donations to global health initiatives will only increase foundations' relative material and agenda setting power.

LOOKING BACK AT THE 'GOOD TIMES'

In order to assess the possible future of global health governance we begin with a survey of the recent past. We first question how good those 'good times' have actually been. The picture is not a simple one. In particular we focus here on two key issues: the new resources which have been devoted to global health and the new institutional architecture which has been created.

In resource terms, especially for a relatively small number of high-profile diseases, these have indeed been boom years. Yet improvements in global health

governance have been highly selective and highly uneven. Indeed, there has been considerable criticism of the ways in which resources have been spent.⁸ For one, much of the new money has been focused on vertical disease-specific programmes at the expense of broader health system investments. Also, huge areas of global health (not least non-communicable diseases) have failed to attract the attention and resources which have been devoted to the 'big three', or to other infectious disease threats. Moreover, there has been little concerted effort to address the social determinants of health and the basic, deeper-going linkages between poverty and health outcomes. There are clear signs of a growing recognition of the need for these shortcomings to be addressed. For example, the WHO's Commission on the Social Determinants of Health advocated strongly for a 'new approach to development' which puts health equity at its heart.⁹ There has been a greater focus on health systems strengthening (HSS) in the second half of the last decade, and non-communicable diseases appear to be rising on political agendas, if the recent September 2011 UN General Assembly session on that subject is any indication. Nonetheless, all these developments are essentially reflections of a history of real governance failure.

The 'good times' have been felt unevenly, and in certain areas of health to the cost of others. But at least there has been real progress, which has obviously been welcomed in those areas that have been prioritised. The political will and financial contributions of the G8 countries have to a great extent driven this progress. Aside from being the majority investors in the new GHPs, they have collectively undertaken a variety of initiatives, such as the commitment to universal access to ARVs and a pledge to invest US\$ 60 billion in fighting disease and strengthening health systems.¹⁰ Other prominent high-profile G8 initiatives (for instance, the debt relief measures agreed at the 2005 Gleneagles Summit) have also had clear benefits for the Global South and have led to greater investments in health in a number of countries.¹¹ The motivations for the G8's actions were clearly complex. For one, it is clear that there was, at the turn of the new millennium, a generally increased level of political concern with issues such as development, debt, and the environment, most concretely expressed in a series of high-level summits (including G8 meetings at Okinawa and Gleneagles) and the Millennium Development Goals. Second, there were some factors which related more specifically to global health. These included a combination of altruism, with key leaders having a genuine interest in health issues, especially AIDS; effective moral shaming tactics (for example, by Transnational Advocacy Networks)¹²; and the catalytic role of the HIV pandemic. Furthermore, issues of perceived national interest played a role, with Western states coming to see their security and economic interests at stake in global health, highlighted by events such as SARS and growing concerns over biosecurity threats. Thus, the political context was a favourable one, but so was the economic context. The huge new investment in health and development occurred after a decade of economic growth and at least commenced at a time of relative economic prosperity in the West.

The uneven distribution of global health financing has also been reflected in the development of new institutions – the most high-profile of which are GAVI and the Global Fund – which have altered the architecture of global health governance. Such new governance mechanisms have been created to respond to the issues which have been prioritised. It was again the leadership of the G8 countries which precipitated this early 21st century wave of institutional creation in the field, developments which have in many

ways defined the last decade of global health governance. The new GHPs and other health and development aid platforms have almost exclusively been initiated, and to a great extent bankrolled, by the G8 countries, often under the UN-backed MDG banner. The other major change to the governance system, and the other major new source of financing, has been the emergence of result of largely US-based philanthropic foundations as major governance actors, the Bill and Melinda Gates Foundation being by far the largest and most influential. Whereas foundations have long been active in international health (in the case of the Rockefeller Foundation from the early 20th century), they have never before been as fully integrated into the global health governance system as they are now.

Taken together, these changes have created a new (but, to reiterate, uneven) governance architecture in global health. For some critics the new plurality of actors has brought costs to the overall system, not least in terms of a lack of overall leadership and questions over accountability. The WHO – traditionally the leading global health agency, and one which has a broad mandate across all areas of health – has seen its primacy challenged and at the same time has come under increasing financial pressure. Yet the multiplication of institutions has not been the only result of the emergence of these actors. The same process has also brought the ascendancy of a new modality or 'way of doing' aid. Elsewhere¹³ we have argued that there has been a shift to private forms of authority in health governance, including a deliberate diffusion of authority from the state and traditional inter-state multilateral forums to new, hybrid public-private partnerships and purely private philanthropic actors. This shift has involved a conscious strategy of engagement with the private sector, especially the pharmaceutical industry, in the generation of governance responses to a very narrowly circumscribed, yet nonetheless important, range of diseases. Many of the new health institutions have assiduously sought to work with the market and private firms to achieve their goals, perhaps most notably in the area of access to medicines, without substantially challenging the role of markets in perpetuating health inequalities.¹⁴ The new modality of health governance has also been reflected in the raft of business techniques, concepts, practices and language, from board structures and accounting standards to monitoring and reporting methods, which have been adopted by the new governance institutions. The new modality of governance has consciously been branded as a new model of *doing business* in aid and health. Whatever the fallout of the contemporary geopolitical changes and economic crises, this modality of governance is in robust health and seems certain to prosper.

A CHALLENGING TIME FOR GLOBAL HEALTH GOVERNANCE

Financial Crisis, Global Health and Overseas Development Assistance (ODA)

As we write (in early 2011), there is a palpable sense that we have just witnessed the first clear signs of an era drawing to a close. The autumn of 2010 saw a number of events which signal the likely direction of global health governance over the next few years, not least the MDG Summit, which took place in September 2010 to review progress towards meeting the goals, and the Global Fund replenishment meeting in October 2010. The pledging conference in GAVI's replenishment process took place in June 2011.

The timing of these events so close to each other revealed a stark disjuncture between needs and available resources, and suggested an ongoing shift in priorities. The MDG Summit pointed to a mixed picture, with progress having been made against some of the targets, but in many areas at too slow a rate to give any cause for optimism that the goals will be met by 2015. The Summit's Outcome Document recognized that much more needs to be done, and more resources provided, while noting that:

“Successes have been made in combating extreme poverty, improving school enrolment and child health, reducing child deaths, expanding access to clean water, improving prevention of mother-to-child transmission of HIV, expanding access to HIV/AIDS prevention, treatment and care, and controlling malaria, tuberculosis and neglected tropical diseases.”¹⁵

The Outcome Document also recognized the impact of the financial crisis, pointing to the setbacks which had resulted from the deteriorating global economic situation. The financial crisis also, inevitably, cast a shadow over Global Fund replenishment, an event which gave few signs that huge increases in resources for global health more generally are likely to be forthcoming. In advance of its 3rd replenishment the Global Fund had outlined three scenarios, setting out the results which it could achieve with various levels of funding.¹⁶ The first, costed at US\$13 billion, was based upon a continuation of existing programmes with a significant reduction in the funding of new programmes; the second (US\$17 billion) would allow both for the continuation of existing programmes and a rate of funding new programmes roughly similar to recent years; the third (US\$20 billion) would allow for both continuation of existing programs and a significant scaling up of the best performing programmes. In the event, the amount pledged (some US\$11.7 billion)¹⁷ fell short of even the amount required for scenario one, and even this total was in no small part due to a significant increase in the US contribution. Opinions are sharply divided over whether this was a relatively good result in the circumstances or a dramatic failure, but it certainly brought a clear reminder of the extent to which the future of global responses to health problems is inextricably linked to wider developments in the global economy.

On October 6th 2010, the day after the Global Fund replenishment meeting ended, it was GAVI's turn to begin the process of persuading donors to contribute to its immunization efforts. GAVI's target was lower than the Global Fund's – it estimates that it needs US\$6.8 billion through to 2015, which meant that it had to raise an additional \$3.7 billion at its June 2011 pledging conference.¹⁸ In the event GAVI's target was exceeded, with significant new donations from the UK (\$1.3 billion), the Gates Foundation (\$1 billion), Norway (\$677 million) and the US (\$450 million). Clearly childhood immunization is currently a high priority for donors and the funding increases reflect that. Questions remain, however, over sustainability, given GAVI's reliance on a small group of large donors, but also over the extent to which increases in GAVI's funding will lead to cuts being made in other areas of global health. As the UK's International Development Secretary Andrew Mitchell said at the time of the GAVI pledging conference, the UK government had reviewed its foreign aid commitments, refocusing its investment on those (like GAVI) which it deemed to be most cost-effective, but freezing or cutting its commitments elsewhere.¹⁹

Elsewhere, the November 2010 G20 meeting in South Korea was dominated by concerns over economic recovery and disputes over currency valuation, and did not

include a focus on global health as some had hoped. Although the G20 did produce the “Seoul Development Consensus for Shared Growth”, this contained no specific commitments on health.²⁰ Earlier in the year, the G8’s June 2010 meeting in Muskoka – another event which many had hoped would have health firmly on its agenda – was similarly disappointing in global health terms. As we discuss in greater detail below, the unprecedented political attention and funding that G8-inspired initiatives have brought to global health can no longer be taken for granted, and there is little serious evidence to suggest that the G20 is presently willing to take on a leading role. Policy priorities seem to have been radically realigned as a result of the financial crisis.

Roodman has shown that previous financial crises have led to relatively long-term declines in ODA across affected developed countries.²¹ In the current crisis, there are already reasons for concern, although the picture is mixed. Countries which have been the highest profile victims of the financial crisis in the developed world such as Italy, Spain, Portugal, Greece and Ireland have cut their ODA spending dramatically. At the same time most of the largest global donors have either maintained, or in some cases even increased, their ODA spending.²² As the financial crisis has impacted on developed country willingness to shoulder the increasing financial burden of global health initiatives, there are moves afoot to attempt to bridge these funding gaps. One proposed method is to more effectively leverage alternative sources of funding, including from the for-profit sector.²³ However, despite the hype surrounding public-private partnerships in health and, notwithstanding private sector representation on the boards of new GHPs, the for-profit sector has not to date contributed in any significant manner to GHP operating budgets.²⁴ Moves are also afoot to increase the contribution from developing countries to their own health sectors: African Union countries, for example, committed as part of the 2001 Abuja Declaration to spend 15 per cent of their national budgets on their health sectors, a commitment which has been honoured only by South Africa and Rwanda so far, and which has in turn led to calls for African Union countries to do more.²⁵

While the major donors have largely maintained ODA for now, it is often forgotten that this is a relatively small proportion of overall health expenditure in the developing world. External funding of health in developing countries was, according to the WHO’s 2006 figures, only 17 per cent of overall health spend, the remainder being made up of out-of-pocket expenditure by individuals and households, and by national government expenditure.²⁶ Both of these domestic funding sources are negatively affected by the financial crisis, as are remittances which peaked in 2007 at some US\$ 251 billion.²⁷ Developing countries are dealing with a ‘double whammy’: as their own national health budgets become constrained by the burden of debt, shrinking tax receipts, and reduced remittance revenues, donor countries are facing similar fiscal constraints. A 2008 World Bank estimate indicated that a 1 per cent drop in the growth rate of developing-country economies would trap an additional 20 million people in poverty,²⁸ with obvious knock-on effects on health status and the ability of individuals to access health services. In early 2009, the WHO convened a high-level consultation on the financial and economic crisis which warned that it threatened the attainment of the MDG health goals as well as public and private (i.e. individual) spending on health.²⁹ In the same year, the IMF and World Bank predicted severe impacts on health status in developing countries, anticipating, for example, significant rises in infant mortality.³⁰ In the case of HIV/AIDS, a December 2009 UNAIDS study on the impact of the financial

crisis on the AIDS response surveyed a range of developing countries, some 60 per cent of which anticipated the crisis having an acute impact on prevention and treatment programmes.³¹ Despite the speculative nature of many of these studies, and the fact that the negative impact of the crisis on funding and national health budgets will inevitably take time to feed through, there are obvious grounds for pessimism. These events are still unfolding and data remains patchy, but precisely the types of negative impacts we point to here have certainly been seen in previous financial crises. A 2009 World Bank report³² examined the lessons of earlier crises in Latin American and Asia and found that in both cases stagnant or decreasing economic growth led to spending cuts in social spending such as health and education, and that in both cases it took many years for expenditure to return to pre-crisis levels. History should lead us to fear for the future health prospects of the world's poorest populations in the present global economic climate.

The USA: Global Engagement and Domestic Politics

Over the past decade, although it has had its critics, the US has certainly shown a significant commitment to some global health issues, most notably HIV/AIDS via the President's Emergency Plan for AIDS Relief (PEPFAR). The US mid-term elections which took place in November 2010 could have profound implications for the future of the US's engagement with global health. The Congressional elections led to the Democratic loss of the House of Representatives and a significantly reduced majority in the Senate. This domestic political shift (and at least the possibility of a similar swing towards the Republicans in the Presidential elections of 2012) could spell massive changes in the US approach to global health. At the time of the election and thereafter there have been clear signals both from the Republican Party itself, a number of influential columnists³³, and from the authors' own concurrent interviewing of the health and aid community in Washington D.C. and New York, that these changes in Congress could be bad for global health. Of particular concern is the Republicans' stated objective of reining in the US budget deficit, which has obvious implications for that country's spending on ODA and health initiatives. In January 2011, a coalition of 165 House Republicans set out a plan for a radical defunding of USAID.³⁴ Subsequently, in the recent build up to the 2011 federal budget settlement of April 2011, the Republicans were pushing for an overall cut of US\$ 63 billion to the federal budget, a cut that included the domestic spending on health and broad swathes of the US ODA budget. The crisis prompted one senior USAID official to testify to a House Appropriations sub-committee that the potential for a 16 per cent cut in the President's international aid request would cost (conservatively) 70,000 lives per year, and in three principal areas of US global health spending: malaria, immunization programs, and maternal health. As it transpired, the Democrats succeeded in ring-fencing the aid budget in a last gasp settlement. However, it is clear that current concerns with the level of US national debt will continue to create pressures on future aid settlements and planning, and the elections of 2012 could be a turning point for the US's pivotal role in global health governance and the wider multilateral system.

The shifting Republican/Democrat balance in Congress was not itself, however, the only notable result of the mid-term elections. The changing internal make-up of the Republican Party was also striking, with the Tea Party gaining considerable traction and

accounting for 28 of the total of 60 new 'pickup' seats in the Congressional elections.³⁵ In comparison with the evangelical right, who were influential under Bush, it seems that the Tea Party cares little for ODA, or indeed any overseas ventures that distract from domestic political issues (especially the economy) and their much vaunted goal of a reduced role for the federal government, both domestically and internationally. If the Tea Party's gains in 2010 represent a sustained shift in the Republican movement, as opposed to a more limited and time-bound protest vote in a time of financial crisis, it could profoundly alter the US approach to foreign and development policy and indeed to the multilateral system more generally, with health being just one area to feel the repercussions of US isolationism and retrenchment. Commentators have noted that there are strong isolationist tendencies present in the Tea Party's diverse ideological makeup, with concerns in foreign policy being narrowed to a preoccupation with declining geopolitical and economic power (especially with respect to China); the need for scaled back overseas interventions; and the recalculation of foreign policy initiatives in terms of national self-interest.³⁶ Much of the success of US-led health initiatives over the past decade has been dependent on maintaining bi-partisan support. This collaborative commitment to health and aid seems in doubt given the combative thrust of the current Republican Party with respect to overall government spending and also health policy, both at the domestic and international levels.

As well as the scale of US ODA, the modality of its delivery is also in part a domestic political issue. Since the Second World War, the US has periodically swung between greater and lesser degrees of multilateral engagement; it has always in practice pursued some mix of the two. Under the Bush administration the focus was primarily a bilateral one, notwithstanding significant commitments to the Global Fund and some other multilateral efforts. Under Obama there has been a notable rhetorical shift towards multilateralism, although in practice the US's engagement with global health is still largely bilaterally-focused. There are real questions over whether the Obama administration's greater willingness to engage multilaterally can survive a hostile Congress.

Changing Geopolitics: The G8, G20, and Emerging Economies

As we outlined above, many of the major changes in global health governance over the last decade have been driven by the G8. We have already discussed some of the motivations for their actions but, as Laurie Garrett has pointed out, part of the story at least was that the G8's status made them subject to "the Great Global Guilt Trip".³⁷ The emergence of the G20 as a forum which will either supplement or supersede the G8 throws the future effectiveness of this guilt trip into doubt. As Garrett argues,

"G20 nations are not vulnerable to such pleas to share their wealth. Most of the G20 are emerging-market nations, still striving to realize the infrastructures of rich countries – roads, schools, energy systems, clinics, universities. If cries of guilt are to be heard in Jakarta, Cairo, Buenos Aires, or Pretoria, they will come first and foremost from the citizenries of the nations in which those grand capitals reside. For countries like India, South Africa, China, Brazil, and Indonesia, the G20 is a mechanism to open markets and escalate their push into the global economy."

There are also questions over whether the other factors which seem to have motivated the G8's efforts on global health apply to the G20. As we have already discussed in relation to the financial crisis, the current zeitgeist is dramatically different from that of the early 2000s, when the G8 first began to involve itself heavily in global health issues. As of yet there have been no determined attempts to push global health as a priority within the G20 in the way that UK Prime Minister Tony Blair (and then Chancellor Gordon Brown) did with the G8 at Gleneagles. Where leadership does exist at present, it is focused on tackling the economic crisis and promoting economic growth. Finally, as we discuss below, as compared to the G8, there appears to be a far greater diversity of views within the G20 about the national interest implications of global health issues. Whereas the G8 have tended to engage with health either as a security or a development issue, some key G20 members are using health to pursue some quite different policy agendas. In short, the factors, both endogenous and exogenous, which motivated a relatively coordinated and sustained G8 response to certain health issues a decade ago will not necessarily be present in today's G20 context.

Clearly the G20 remains at an early stage of development, and how labor will be divided between the G8 and G20 is as yet unclear. However this plays out, the creation of the G20 is a clear manifestation of the current shift in geopolitics and the global economy in which emerging economies are playing new roles on the global stage. Several of these middle-income countries are increasingly flexing their muscles in global health diplomacy, and as such are important in assessing the future of global health governance. Among the most prominent of these are China, Brazil, India and Indonesia, each of which has come to play an important role in global health governance, although in different ways and over different issue areas.

China's approach to global health is a particularly interesting one. China has not traditionally pursued multilateral approaches to international aid, nor does it generally follow the Paris Guidelines. Its contribution to global health and development remains largely focussed upon bilateral arrangements with specific countries, often in the form of infrastructure developments, and often in return for access to primary resources. Indeed, China has to date never had a dedicated development or aid agency and often, as in the case with projects in eastern Africa, projects are conducted by specific Chinese government ministries such as the Ministry of Commerce or by regional or local authorities. Also, whilst investing substantially in a series of specific projects, often including significant contributions to the health workforce, China has not tended to engage in projects which can be easily scaled up to country-wide or even regional programmes. Moreover, China has only collaborated with other aid agencies such as DFIDs in a very limited manner.

At the same time, China has received some praise - not least from African leaders - for *not* linking aid and investment to political conditionalities such as good governance or human rights, and for injecting new 'competition' into a tired Western-dominated model of aid and development. As recently as April 2011, the Chinese government published its first ever White Paper on the future of Chinese aid.³⁸ The paper surveyed some five decades of Chinese aid policy, linking its recently expanded engagement in international aid with its own economic development. The white paper gives no reason to suspect that the bilateral and discrete project model will be abandoned in the near future, although levels of aid are announced as set to rise and some moves are being made toward greater transparency. This will have a real impact on the future of

multilateral global health efforts, not least for funding mechanisms such as the Global Fund. China's pledge for 2011-13 at the October 2010 Global Fund replenishment conference was a paltry US\$14 million. By contrast, Japan, which China has recently overtaken as the world's second largest economy³⁹ pledged US\$800 million.⁴⁰ Indeed, as Chow has pointed out, China has been the fourth largest recipient of grant money from the Global Fund, receiving over \$US1 billion.⁴¹

Aside from the economic implications of China's lack of serious engagement with such initiatives, there are political ramifications too. Within the geopolitical context of what some have seen as an emerging 'G2' of China and the USA,⁴² China's model could have knock-on effects for US policy. For some years there have been concerns within US policy communities that the Chinese model of aid is a very effective exercise in soft power,⁴³ and that "PRC assistance often garners appreciation among foreign leaders and citizens disproportionate to its costs"⁴⁴, with China seeing greater improvement than the US in public perception in recipient countries.⁴⁵ It may be that these concerns will interact with the new domestic political context within the US and will be used in order to inspire the US to shift its own development aid even further towards bilateral models in an attempt to counter China, and to use global health investments even more to further its own geopolitical interests.

While China is largely going it alone, the rise of other middle-income countries is creating tensions within the existing multilateral system of global health governance. Countries such as Brazil, India, Thailand and Indonesia are increasingly exerting both direct and indirect influence on a range of issues across multiple fora. To take some examples, Brazil and India (along with others, including Indonesia and Thailand) have together posed a significant challenge to the international political economy of access to medicines, acting as leaders of a loose alliance of developing countries in various multilateral fora, such as at the WTO Doha Ministerial and in WIPO. Indonesia has recently posed a high-profile challenge to the WHO's long-standing global influenza virus sharing arrangements.⁴⁶ Brazil has sought to challenge the language of 'global health security' within the World Health Assembly, arguing that there is no agreed definitional basis for the WHO's use of the term.⁴⁷ These countries, then, have demonstrated the willingness and ability to challenge the status quo and also to provide leadership, as Brazil did over the negotiation of the Framework Convention on Tobacco Control.⁴⁸ Thus, the rise of these powers and the expression of their real interests is already injecting both dynamism and greater contestation into global health governance. What is also striking is that the influence of other regimes (such as those governing trade and IPRs) on global health outcomes are being highlighted and targeted by these parties. Health governance has thus become ever more complex, multi-nodal, and multi-levelled. The challenge of leadership and direction in global health is thus made more acute, although the presence of genuine plurality and different voices in the making of health policies can only be welcomed in the longer term.

THE PERSISTENCE OF THE PUBLIC-PRIVATE MODEL

Despite these contemporary challenges to the existing system we argue here that one of the key features of global health governance which developed in the 'good times' – the incorporation of private forms of authority into what was previously essentially a 'public' global governance system – will nevertheless persist, and indeed become even more

deep-rooted. From the WHO under Brundtland, who came to accept the need to work with the private sector and the possible advantages offered by leveraging private sector resources and expertise to meet global health goals⁴⁹, to the inclusion of private sector representatives into the boards of the new GHPs, the 21st century has seen private forms of authority in global health governance become widely, but not universally, seen as legitimate and desirable. This 'private turn' in governance is related to a longer-standing trend towards 'the private' (and the market) in the delivery of healthcare products and services, at least at the domestic level in many states. As in other areas of global governance, with which it shares many commonalities, we have seen a marked relocation of authority in global health governance away from states and traditional international organisations and towards private and hybrid public-private actors.⁵⁰ GHPs and private philanthropic foundations have thus emerged as central parts of the global health governance architecture. The current challenges that this paper has described will not seriously undermine this relocation of authority. Indeed they will entrench it. Above we identified a diffusion of authority among states, but there has also been a no less significant relocation of authority away from the state and multilateral bodies such as WHO.

We argue here that there are both practical and ideational reasons to believe that private forms of authority are here to stay in health governance. On a practical level, institutions once created are notoriously hard to dismantle, even where the will to do so exists. Organizations such as the Global Fund, GAVI, IAVI, Roll Back Malaria, Stop TB and others have all been created as public-private partnerships and have all come to be central parts of the global architecture in their particular fields. Some of the largest of these public-private actors have also become integral parts of inter-organizational collaborative frameworks such as the Health 8, which brings together UN System bodies (WHO, UNICEF, UNFPA, UNAIDS and the World Bank), GHPs (The Global Fund and GAVI) and the Bill and Melinda Gates Foundation. These institutions have thus become woven into the very fabric of global health governance.

But beyond this, on an ideational level, these organizations now have established track-records and, notwithstanding criticisms from some quarters, are generally relatively highly regarded. The GHP model certainly has many influential supporters. For example, Jeffrey Sachs, former Chairman of WHO's Commission on Macroeconomics and Health and one of those behind the original idea of the Global Fund, has claimed that the Global Fund was "arguably the most successful innovation in foreign assistance of the past decade".⁵¹ Indeed, he has suggested that it should also be addressing MDGs 4 (child mortality) and 5 (maternal health) as well as its existing core mandate of MDG 6 (HIV/AIDS, TB, and malaria) through a new emphasis on health systems.⁵² And while the future funding of GHPs during the current financial crisis is clearly uncertain, they are by no means unique in this respect - indeed the WHO is in some respects in an even worse position⁵³ - and these pressures should not be seen as indicative of widespread doubts about the viability of the model. Moreover, that model may well interact with the financial crisis to make the new health actors a first choice for the disbursement of state aid. They have set out their stall as being leaner, faster, more efficient and more transparent than traditional mechanisms - all of which is music to donors' ears, especially in times of austerity.

This is not to suggest, however, that GHPs will not themselves come under pressure to reform and improve as resource constraints bite. Donors' concerns over

their ability to hold global health institutions accountable is increasing pressure on both new and old actors to better demonstrate effectiveness and value for money. Andrew Mitchell's comment above about the prioritization of funding GAVI due to its perceived cost-effectiveness is a perfect example of how this plays out in policy terms. The new institutions are, arguably, and certainly by their own account, in a better position to respond to this agenda not least because of the emphasis which GHPs have placed on principles and practices derived from the world of modern business, rather than traditional international aid. This is often seen most clearly through the language that they use. Their websites and promotional literature are replete with terms such as 'best practice', 'cost effectiveness', 'entrepreneurialism', and 'efficiency'. Similarly, their activities and governance structures often reflect those of corporations, and they judge their success (and plan their future activities) on the basis of performance measurements, formal auditing and so on. Whilst such activities are not alien to any large international organisation or NGO, it is the degree to which GHPs have explicitly mainstreamed them into their activities that is striking and novel. Overwhelmingly, they tend to be results-oriented institutions, a factor which further increases their attractiveness to donors in the current political and economic climate.

So far we have focussed largely on GHPs, but one of the other clear motifs of 21st century global health governance has been the influence of large philanthropic foundations. The Gates Foundation in particular has become incorporated into the mainstream as a governance actor in ways which have not yet been seen in other sectors. The agenda-setting power which this (and the resources at its disposal) has given the Gates Foundation is clear, and in discussions with officials across a wide range of organisations, from the WHO to GAVI, one thing is evident: when Bill speaks, they listen. And, as long as the Gates Foundation has the ability to deploy such huge resources, these organisations will continue to listen. Indeed, these foundations seem to have escaped relatively unscathed from the financial crisis and are not under the financial pressures that other global health actors presently face. If we are to indulge in some speculation about the future of foundations in global health, it may be that their influence will increase over time and that other foundations will emerge alongside the Gates Foundation as key players. The Carso Foundation – founded and funded by Carlos Slim, currently the world's wealthiest individual – is one potential candidate.

CONCLUSION: ARE THE 'GOOD TIMES' OVER?

For all of the reasons discussed above, it seems more than likely that the 'good times' in global health, such as they were, may well be over. We began by noting that we have witnessed in recent years a radical transformation in the global governance of health. It seems doubtful that the energy, enthusiasm, and (in many cases, genuine) commitment to addressing global health challenges that we saw in a generation of world leaders at the turn of the millennium is still there. In some areas much progress has been made and, as we noted above, we are starting to see real gains. In other areas – not least in relation to access to quality health services and, even more so, in relation to the social determinants of health – far too little has been done. The danger now seems to be that global health initiatives will be scaled back, and incipient attempts to tackle the weaknesses of many health systems, to address the social determinants of health, and to deal with neglected diseases may wither on the vine. The financial crisis is one powerful

reason for fearing this, but it is not the only one. Dating the end of global health's 'political revolution' to 2008, Fidler has argued that four crises – in energy, food, climate change, and economics – have revealed the scale of the challenges that global health faces.⁵⁴ Yet, like us, he sees evidence of some gains having been made:

“Prior to its political revolution, global health had developed no serious linkages with, or credibility in, the policy communities tasked with protecting a country's vital national interests in security and economic wellbeing. Global health now interfaces with these communities and interests, but its influence in these areas is limited, particularly when crises are not caused by the sudden, severe, and large-scale disease threats.”⁵⁵

This is surely right. Health does now have a seat at the table; but, as Fidler also notes, it remains vulnerable to being barged aside by competing global priorities. There should be no surprise about this – it was ever thus. Priorities wax and wane. In fact, perhaps the bigger surprise should be that the 'good times' ever came at all. The achievements of the UN's 'Development Decades' of the 1960s, 1970s, 1980s, and 1990s gave little cause for optimism. But during the MDG period, international development and global health have had a serious place on the global political agenda.

Although the resource boom of the last decade seems certain to be over in the short-medium term at least, we have argued here that the basic governance model which has been established over the last decade or so will persist. In particular, private forms of authority (whether in the form of GHPs or foundations) will continue to be – and indeed are likely to become even more – central to the fabric of global health. Indeed economic pressure will almost certainly bolster the attractiveness of this model to policymakers in key donor states.

Finally, whatever the outcome of the financial crisis on global health, it is possible that it will interact with powerful contemporary neoliberal policy templates in at least two ways. First, as is currently being witnessed in the UK context, fiscal austerity could well become a mechanism (and justification) for the liberalization of remaining welfarist national health systems. The rolling back of the state in health as a result of public debt has been a pattern for imposed cuts and liberalisation measures in developing countries for at least three decades. That trend is unlikely to disappear in the current climate. This will have profound implications for health systems strengthening efforts (whether they are market- or public-oriented), and it will only increase the gaps in health service provision. Subject to continued funding, it may be that many of new hybrid actors in global health will actually find themselves being asked to provide more services than ever before, and working with a bolstered private health sector in these efforts. Second, neoliberal policy templates may also interact with the crisis so as to vest even more authority in global economic organisations, namely the World Bank and IMF. These bodies are often viewed (and certainly present themselves) as having the ability to manage economic recovery and the role of health spending and planning within it. There is reason to be wary of the effects that their prescriptions for global policy and national spending priorities may have on health.

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