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The Need for Policy Coherence  
and New Partnerships



## **Anarchy vs. Coherence in Global Health Governance**

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## Abstract

Since the late 1980s there has been a proliferation of new actors in global health politics linked to a transformation from a Westphalian system of international relations to a post-Westphalian system of global politics. Talking of a transformation from international to global health governance means that in particular the number and significance of transnational non-state actors (civil society organizations, private foundations, but also transnational pharmaceutical corporations) and of hybrid organizations (like public-private partnerships) has increased. In addition, conflicts between different sectors of global governance have intensified, in particular between the international trade system (incorporating intellectual property rights) and health. This proliferation of actors has certainly helped to mobilize additional resources, to increase attention to the lack of access to medicines and health services for poor people through advocative action and has led to a growing flexibility of global health governance in reacting to global health challenges. On the other hand, it also implied a frequently inefficient use of the resources mobilised through uncoordinated efforts of various actors in the same field and, in particular, even increased the difficulties of developing country governments to improve their health systems in a coordinated manner.

Based on a research project on “Global health governance and the poverty-oriented fight of diseases”, which focussed on institutional chance related to the fight against HIV/AIDS and the results of a conference on “Defining and Shaping the Architecture of Global Health Governance “ the paper will ask whether some form of management of global governance processes which are basically self-organized is possible. Is there a chance to reach more coherence in global health without giving-up the gains of an open system of governance? The paper will analyse the perspectives of an improved cooperation in this field looking

- (a) at the perspectives opened up by the Paris Convention on Development Effectiveness and the resulting process and
- (b) at the potential of international expert commissions sponsored by intergovernmental organization to bring together diverse actors in a field of governance and at the same time to open-up negotiating processes towards binding international agreements (example of the WHO sponsored Commission on Intellectual Property Rights, Innovation and Public Health and the Intergovernmental Working Group on “Public Health, Innovation and Intellectual Property” established by the World Health Assembly in May 2006.

## **(1) Introduction**

In a very short-hand definition, globalization can be characterized as the intensification of cross- and trans-border flows of people, goods and services, and ideas. This process has been accompanied by innovation in many fields and new opportunities for economic and social development, but also growing inequalities and risks, in particular, due to a decreasing control of governments on the national levels. This has led to increasing attempts for more effective collective action by governments, business and civil society for a better management of these risks and opportunities, which also has opened up new fields of political conflicts in an arising arena of global politics.

The tightening fabric of social relationships in an emerging world society also has important consequences on global health, both in terms of the rapid global spread of disease and in terms of the significance being attributed to the social and economic consequences of the poor health situation of a considerable proportion of the world population. A whole range of aspects point to the fact that health has become a key global concern:

- A more rapid spread of health problems can be observed: on the one hand, as a result of the expansion and acceleration of global mobility (in particular transmission of infectious diseases), and on the other hand, from the globalization of consumer habits as a consequence of advertising and cultural assimilation (for example smoking, changing nutritional patterns).
- The increasing resistance of pathogens to antibiotics holds great dangers. Dangers result, not only from the excessive use of these drugs by the middle and upper classes, but also from inadequate medical supervision in poor countries, and from the widespread use of antibiotics in livestock production.
- The accelerated spread of drugs and medical technology to virtually all corners of the globe has the potential to help the fight against disease worldwide. However, as the income-based inequalities in healthcare are becoming ever more evident, this is increasingly posing ethical problems.
- In the face of the debt crisis and when priority was given to macroeconomic restructuring in the 1980's, socio-political programmes (such as health policy) stood no longer at the centre of development cooperation. The crisis manifesting itself in primary health care became clearly visible during the 1980's. In the poorest countries, even the most basic types of provision (vaccinations, pre-natal care) were inhibited by lack of funding (Werner, Sanders, 1997).
- Since the mid-1990's, there has been a growing apprehension about the vicious circle of rising poverty and greater vulnerability to health problems in an increasingly global society. People are becoming ill more frequently due to poverty, while the illness in turn simply makes them even poorer particularly, when there is no adequate public health service.

In the face of the international health situation, the governments of the OECD countries are becoming ever more concerned about both the spread of infectious disease across borders and the possible political and economic instability that is associated with a high incidence of poverty-related disease in some regions of the world (such as HIV/AIDS). This is one reason for the increasingly important role played by health since the 1990's. Prime examples of this role include the G7 and G8 summits and the declarations adopted at these (Cooper et al., 2007, part IV).

Health is also increasingly affected by factors outside of the health sector – trade and investment flows, communication technologies, collective violence and conflict, illicit and criminal activity, environmental change and various regimes which, by aiming at a regulation of these factors, have a more or less profound impact on health policies and health outcomes. For example, the liberalisation of international trade (including the international regulation of intellectual property rights by the TRIPS Agreement) reduced the level of control individual nations had over the production of and access to medicines. Furthermore, as in other policy fields, we can observe a process of transnationalization with non-state actors such as transnational corporations (TNCs), civil society

organizations (CSOs), private foundations and hybrid organizations (public-private partnerships) having a growing impact on the rules, norms, institutions and organizations that govern health policy and practice at the sub-national, national, regional and global levels.

This proliferation of actors – we might call the result with David Fidler, an “unstructured plurality” of actors and concepts in global health (Fidler, 2007: 3-4.) – has certainly helped to mobilize additional resources, to increase attention to the lack of access to medicines and health services for poor people through advocative action and has led to a growing flexibility of global health governance in reacting to global health challenges. On the other hand, it also implied a frequently inefficient use of the resources mobilised through uncoordinated efforts of various actors in the same field and, in particular, even increased the difficulties of developing country governments to improve their health systems in a coordinated manner (see also: Lane/Glassman 2007).

In the following two chapters I will shortly characterize the basic features of the transformation from a Westphalian system of international relations to a post-Westphalian system of global politics and the dynamics of Global Health Governance (GHG) as they have developed since the 1990s. In the second part of my paper I will look at two quite different forms of reaction to the increasingly anarchic development of global governance structures: the attempt to improve the effectiveness of development cooperation initiated by the *Paris Declaration on Aid Effectiveness* and the increasing use of international high level commissions as an inclusive form of problem solving. The paper will have a basically explorative character, being based on more extended research on the structure of GHG (Hein et.al. 2007) and moving on to offer some propositions on the relationship between “chaos”, coordination and coherence in a situation characterized by (a) poverty and poor health in the developing world and risk-averting strategies of the rich, and (b) the growing role of transnational private actors as a challenge to a state-dominated global polity.

## **(2) Transformation from a Westphalian system of international relations to a post-Westphalian system of global politics**

The ongoing changes in international relations have been described in terms of a transformation from a Westphalian system of nation states to a Post-Westphalian system of global politics, a transformation, which is still far from being completed. The discussion on global governance has contributed many elements towards an understanding of this process. Figure 1 illustrates this transformation of international relations into a system of global politics. It is not intended as a model of global governance but rather as a scheme to characterize the dissolution of the ‘old’ structure of international relations in the process of a rapidly increasing density of transborder social, economic, and political relations. Compared to the Westphalian system of international relations, Post-Westphalian politics are characterized by a much more complex and flexible system of interfaces which constitutes a challenge to any analysis of global governance.

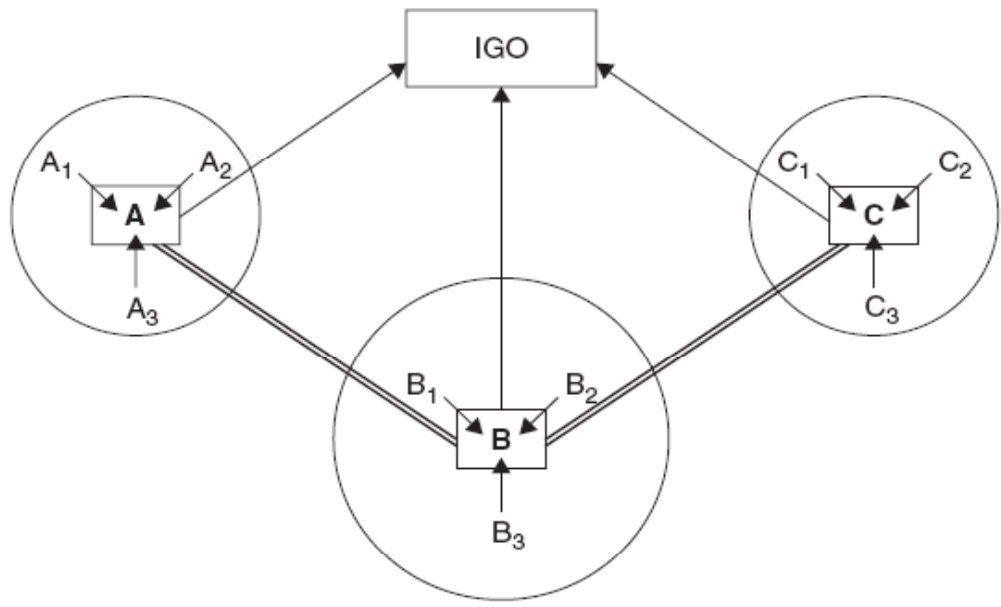
The traditional Westphalian system of international politics was based on an aggregation of interests at the national level (see figure 1: A1, A2 and A3 represent various interest groups – for example business, unions, CSOs – in nation A, and so on). Thus, negotiations at the international level were led by governments on the basis of these nationally aggregated positions, which, in the first instance, reflected power relations within nation states; social groups without much leverage in national politics, had little chance to find their interests represented in international politics. Consequently, the outcome of international bargaining was a result of power relations between nation states, either mediated by decision-making procedures within International Governmental Organizations (IGOs) or various characteristics of specific countries (or group of countries) within the international system. In Figure 1,

the larger circle around country B reflects its central position within the system and points to its hegemony.

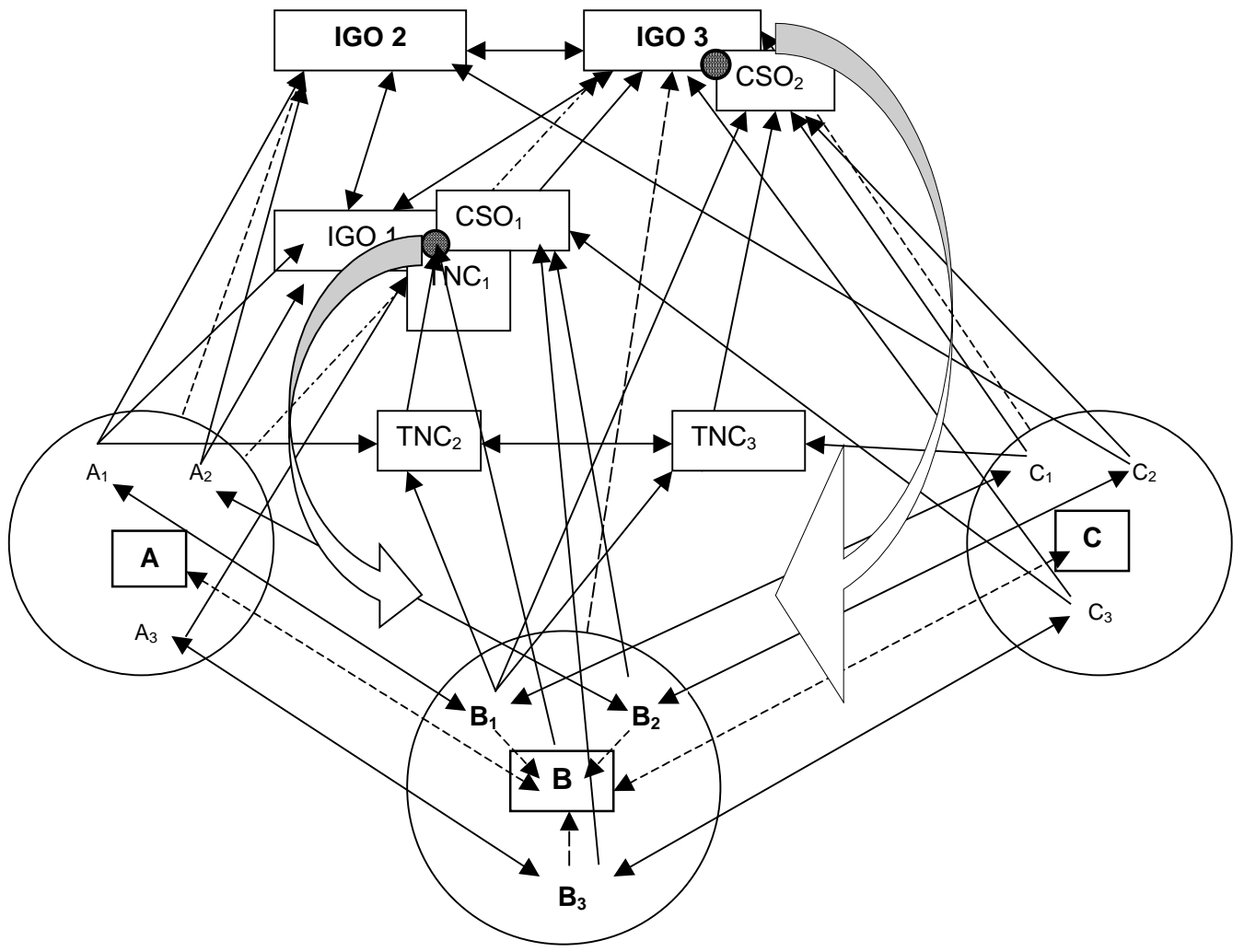
Globalization, the liberalization of markets, and the growing need to deal with transnational/global problems, created the opportunity for the direct interaction of non-state actors. As a result, new transnational spaces of interests and power have been established, which prevent a full aggregation of interests on the national level. Through a transnational cooperation of non-state actors dynamics and opportunities are produced, which increasingly limit the political options of nation states. Even by simply designing hypothetical transnational relationships for three different non-state actors from three national societies, we arrive at an extremely complex structure of interactions. However, in post-Westphalian politics there are many possibilities for cooperation and conflicts among nation states, IGOs, CSOs, and transnational corporations. The 'old' actors of the Westphalian systems do certainly continue to play a powerful role, but their roles are transformed by seeing their former political monopoly challenged through the emergence of new, genuinely transnational actors. Now, non-state actors, who had few chances to see their interests represented by national governments, could gain access to global politics, represented by advocative organizations. This explains the growing complexity of the concept of "governance" in the analysis of post-Westphalian politics. At this point it should suffice to say that we define global governance as the totality of collective regulations to deal with international and transnational interdependence problems (Mayntz, 2005; Bartsch/ Kohlmoorgen, 2005). This includes the political endeavors of all types of collective actors who aim to solve specific problems and to shape a specific field of global politics, taking into account power relations within the global polity (see below for this concept).

New nodes (represented by small dark circles in the figure) appear in the transnational political space (see Burris, Hein and Shearing, 2008 for the concept of nodal governance), which coordinate power resources and compete for shaping global governance processes. These nodes, which might be CSO networks linked to IGOs but also specific coordinating bodies within IGOs integrating other transnational actors (including TNCs), interfere with the aggregation of interests at the level of the nation state in a threefold manner:

- (1) they are centers of transnational discourses and of a transfer of resources which is less directly linked to national governments than in the Westphalian system,
- (2) they constitute power vectors with a significant impact on national decision-making processes, and
- (3) international governmental organizations tend to regain importance as nodes of interaction between states and transnational private actors and, as they constitute fora where the latter - with an inherent deficit of legitimacy concerning decision-making in public affairs - interact with state actors to influence the evolution of international law and regulatory processes.



(a) International relations in a Westphalian system



(b) Global Politics in a post-Westphalian system

**Figure 1: Transformation of international relations into a system of global politics**

As many IGOs have a sectoral focus, links between different IGOs will intensify to clarify issues, which transcend a sectoral policy field such as the impact on trade-related regulations on health matters. Thus, for the fight against social injustice and the governance of social affairs, national states tend to play a decreasing role, just as social and political risks are more and more globalized. The *rise of a global polity* (Ougaard and Higgott, 2002) relates to this dialectics of inequality and the reactions of wealthier actors to risks and to problems of global equity inherent in problems of global health. Structures of conflict and compromise, that is the aggregation of political interests, are also increasingly globalized and linked to the need of an effective reaction to global challenges. The transformation of the Westphalian System can be seen as a dialectic interaction between rather inert institutional structures of the nation state system, the increasing needs for reacting to global challenges (as indicated by the issues referred to in the introduction) and new organizational possibilities opened up by the various dimensions of globalization (organization of production, communication, cultural glocalization, expanding system of intergovernmental organizations). Through the foundation of new IGOs and reforming the old ones, the Westphalian system tries to adapt to globalization, but due to its anchorage in formally sovereign nation states (with their monopoly of legitimate law making and use of force), this capacity of adaptation remains limited. On the other hand, the expansion of interactions between non-state actors is quasi-unlimited, but there does not exist a capacity to create legally binding systems of coordination and decision-making in competition with the nation-state system. Furthermore, the different levels of state organization (local, provincial, national, possibly global) play a central role in the organization of public services, therefore also in the development of effective health systems in poor countries.

Thus, in an abstract theoretical perspective two options remain: On the one hand the perspective of a global state which would produce a new global layer of sovereignty (of global law-making based on a global citizenship and global monopoly of legitimate use of power), on the other hand a new form of social self-organization of proliferating networks, where questions of effectiveness and legitimacy remain unclear (see. Hardt/Negri 2000).

### **(3) The recent dynamics of Global Health Governance**

More than most other policy fields, GHG is characterized by this transformation of international relations into a system of global politics. Compared with the situation in the 1970s, in which above all the World Health Organization (WHO) shaped global health policy, developments linked to globalization have led to fundamental changes in the requirements for improving global health and to changes in the institutional characteristics of global health policies (Lee, 2003; Lee, Buse and Fustukian, 2005). The demand for an *improved access to medicines* and the *fight against HIV/AIDS* constitute the most important starting-points for this proliferation of actors.

Medicines have always played a central role in the treatment of disease and in most societies, they have long been developed and manufactured by private stakeholders. Hence, they have also frequently been the cause of conflict between public authorities responsible for health policy and private enterprises pursuing quite different interests. The latter naturally base research and development on the chance of bringing to market those products which promise a profitable rate of return. With regard to medicines, this causes two kinds of problems which are closely linked to an uneven spread of technological progress in pharmaceutical research and development and also to international trade rules designed to support globalization based on a liberalization of markets:

(1) On the one hand, small profits can be made from drugs or vaccines for illnesses found only in poor countries. This means that research in this area has long been neglected by the technologically more advanced transnational pharmaceutical corporations (TNPCs). This even holds true for very

widespread diseases such as malaria and tuberculosis, where the funding provided for research has fallen far short of the relative significance of these diseases. The problems surrounding these so-called "neglected diseases" increasingly became the topic of debate from the late 1980's onwards. In the 1990's, this resulted in the development of a range of Global Public Private Partnerships (GPPPs). These cooperative ventures were, for the most part, set up on the initiative of the WHO, and were mainly financed by state contributions and later, increasingly by large charitable trusts (particularly the Bill & Melinda Gates Foundation). Pharmaceutical companies were responsible for the scientific and technical aspects of the operation. In the case of the Drugs for Neglected Diseases Initiative (DNDi), a civil society organization, Doctors without Borders (Médecins Sans Frontières, MSF), developed a cooperative framework bringing together international organizations, government institutes (in the field of drug research and production), and private manufacturers of pharmaceuticals to work on various projects in this field.

(2) On the other hand, drugs developed by pharmaceutical companies in response to demand in developed countries are sold at such a high price during the period of patent protection (generally 20 years) that the costs of research and development are easily recovered. In the developing world, however, few people can afford these drugs. As long as no internationally enforceable patent protection was in place, it was still possible to produce generic versions of these drugs in technologically more advanced countries such as India and Brazil. This changed when the TRIPS Agreement came into effect in 1995, even though its cover was at first not comprehensive due to transitional arrangements.

In the case of HIV/AIDS and the antiretroviral (ARV) therapies developed due to demand in the industrialized countries, the situation arose whereby drugs were available that, for practical purposes, turned AIDS into a chronic illness, but at a price which the majority of those affected worldwide could not afford. The problems surrounding access to drugs was highlighted by the fact that Indian pharmaceutical companies were manufacturing generic versions and offering them at less than one tenth of the price of the original versions. However, these could not be sold in many developing countries in which a TRIPS-compatible patent law was already in force. Conflicts arose around the Brazilian HIV/AIDS program, which at an early stage guaranteed universal access to ARV treatment, but which had to fight hard with TNPCs for licenses and imports of drugs at prices that allowed the country to carry on with its program. Diverse initiatives by CSOs supported the demands of developing countries so that they were able to make use of the flexibilities in the TRIPS Agreement (linked to the right of member states "to protect public health" (Art. 8.1)) and to do so safely. These flexibilities made it possible to import generic versions of drugs (via so-called parallel imports) and grant compulsory licenses for the production of generic drugs (Doha Declaration of 2001 and subsequent negotiations). In December 2005, the TRIPS agreement was amended to allow countries unable to produce generics themselves to issue compulsory licenses to foreign producers.

The problems and conflicts surrounding access to medicines have clearly pointed to the close interdependence of international regimes hitherto regarded as separate (not only trade and health, but also human rights and health) and to the growing importance of new stakeholders and institutional forms. This has brought about diverse forms of cooperation between civil society, governmental (national and international) and private sector stakeholders. Since 2000, the sharp reduction in the cost of first-generation antiretroviral therapies has for the first time placed treatment within the financial reach of those infected with HIV in developing countries. Still, poor countries could only finance treatment with foreign aid, and in addition, other measures necessary to combat the disease (prevention, diagnosis and monitoring) require considerable funds that far exceed the amounts traditionally provided as aid in the health field.

This situation has been leading to further innovative approaches. For one, an attempt was made to create synergies: UNAIDS (the United Nations Programme on HIV/AIDS) was founded in 1995/96,

with the primary aim of improving coordination between the organizations involved in the fight against HIV/AIDS. It created an organizational interface between the most important actors, including ten UN organizations (among others: WHO, World Bank, UNICEF, UNESCO, ILO, UNDP) as the co-sponsors; furthermore delegates from 22 nation states and from 5 Civil Society Organizations are represented on the Program Coordinating Board. Poor in resources and dependent upon voluntary cooperation, however, it has never realized its potential to rationalize and coordinate UN actions. The key developments (the G8 Initiative leading to the Global Fund, the mobilization of CSOs to improve access to drugs) took place outside the sphere of UNAIDS.

The establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) represents the farthest reaching initiative in terms of international health funding. The purpose of this fund, which was supported by the UN General Secretary Kofi Annan, stems from the G8 proposal to make considerable funds available for the fight against HIV/AIDS. Since some G8 members refused to allocate funds via a UN organization (which was seen as not sufficiently "result-oriented"), an independent fund was established, based on the PPP model (state governments, representatives of private enterprise and civil society organizations as decision makers; IGOs only as non-voting members of the Executive Council). PPPs (particularly the so-called Accelerated Access Initiative) were also established as a vehicle for enabling pharmaceutical companies to make drugs cheaply available to developing countries in the spirit of Corporate Social Responsibility (CSR) without affecting patent rights. In addition to this, the US programme, PEPFAR<sup>1</sup>, should be mentioned. This is a bilateral programme, which makes considerable funds available for combating HIV/AIDS. In the end, the WHO more actively engaged in this process through the "3 by 5 Initiative" (aiming to treat three million people in 2005). When it became clear that, despite a considerable increase in treatment levels, this target could not be achieved, the plan became that of "universal treatment by 2010".

The very problems surrounding the treatment of HIV/AIDS, however, have again strongly highlighted the importance of properly functioning health systems. Despite the considerable increase in international aid to combat HIV/AIDS since the beginning of this decade, the inadequate infrastructure of the health service in many countries receiving aid has increasingly proved a problem (accessibility of medical facilities, diagnostic capacity, shortage of health service staff, etc.). Aid coming from many different institutions has created problems with coordination and has not exactly made it easier to develop integrated national health systems. As a result, the quest for a *new architecture of global health governance* has been voiced and discussed by many authors.

David Fidler, however, who had introduced the term of 'Post-Westphalian Public Health' into the debate on GHG (Fidler 2004), in a recent article challenged the term "global health *architecture*", stressing that "architecture" is not an adequate metaphor for understanding the current "open-source anarchy" which is characterizing the current broadening and deepening of the normative basis for global health action (2007: 9f.). "Anybody can access, use, modify and improve" (ibid.: 9) GHG as in the case of open-source software. This means that the interactive space of relations between national societies is no longer dominated by state relations. Transnational relations are not squeezed into diplomatic rules and traditional means of exerting pressure on other states in the field of power politics or through complicated mechanisms of international organizations. Actors can use their specific means to reach their goals (financial and expert resources, discourses and using them for mobilization of support, including for influencing the process of international law-making), whenever they consider it appropriate. Transnational networks between health-oriented actors have been formed that focused on specific issues (like access to medicines, neglected diseases, tobacco control etc.) forming a complex web of global social relations related to the issue of global health.

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<sup>1</sup> PEPFAR stands for The President's Emergency Plan for AIDS Relief. This bilateral US programme of massive funding to combat HIV/AIDS came as a surprise, since it takes possible funds away from the GFATM, the establishment of which was also supported by the US.

Complex international agreements (like the WTO agreements, but also bilateral trade agreements) still point to the problem of Westphalian international relations: national governments define “national interests” according to the result of interest aggregation at the national level, which frequently implies a dominance of powerful economic interests over social issues like the health impacts of Intellectual Property Rights (IPRs). Now, actors which pursue particular interests can go “transnational” on its own and seek alliances with other non-state actors and try to have an impact on global social relations, which then – if necessary – can exert pressure on international organizations or specific states (including that of its country of origin) to change legal regulations and/or to effect a transfer of resources controlled by states. Thus:  $A_1$  and  $A_2$  cooperate with  $C_2$  to change strategies of IGO 2, or they may cooperate with another international organization and possibly also a transnational corporation to affect a new global strategy to fight a specific disease (for example by establishing a global public-private partnership like the “Medicines for Malaria Venture”). In effect, some comparatively stable networks with strong nodes might develop which have a more profound impact on the course of events than governmental cooperation. A single partnership as such will not produce strong impacts on the governance of global health, but the totality of these new actors and networks do change the character of the system.

Whether discussing the chances or the problems of a proliferation of non-state actors and of hybrid health partnerships for GHG, it has to be taken into account, that these developments have quite different impacts in different fields of health politics. Mobilizing financial and human resources for specific groups in need might work without much state involvement on either side. The development of coherent health systems (Fidler calls it the “hardware” of health governance (2007:13)) is best served by a well coordinated support and an effective state control. It should not be forgotten, however, that health outcomes depend to an important degree not only on state coordination, but on binding regulations (approbation of doctors, registration of medicines, regulation of trade and IPRs etc.) - regulations which have to pass state authorities but which are the result of political processes, which are increasingly influenced by transnational actors (international regulations and their political environment, networks of CSOs).

#### **(4) Management of GHG: More coordination without giving-up an open system of governance?**

The development of GHG has been analyzed by an increasing number of scholars and observed by practitioners with a certain scepticism. On the one hand, there is little doubt that during the last ten years global political actors have paid an increasing attention to global health issues, that resources available for health care have risen by a considerable amount and that GHG in general acquired a much higher attention in global politics than in the decades before. On the other hand, we find a strong uneasiness among practitioners in GHG about the proliferation of actors in global governance and the fluidity of processes and the insecurity about how GHG can be “governed”. Therefore, it is not surprising that in a broad range of GHG organizations the process leading to the *Paris Declaration on Aid Effectiveness* was greeted with optimism. *Global/international high level commissions* constitute another political form which reacted to the need for coordination within GHG - these commissions had quite a different political goal than aid coordination. They are generally organized to promote a thorough discussion about the most important stakeholders on very fundamental questions and conflicts. In the following two chapters I will shortly review the experience of both forms of coordination.

In the analysis of the Paris Declaration and of international high level commissions I will use the following criteria to reach conclusions on their potential roles in the further development of GHG, though at this stage of my research a systematic evaluation will not be possible:

- (a) How are the problems characterized which should be solved? Is the transformation of the international system sufficiently taken into account?
- (b) What is the approach towards coordination?
- (c) Which short-term results can be observed? What results can be expected concerning the problems of global health inequality and the transformation of the international system?

## **(5) The Paris Declaration on Aid Effectiveness and GHG**

In the second half of the 1990s the World Bank stressed that a central point for the success of poverty reduction strategies is an improved coordination of donor politics, i.e. of multilateral, bilateral and private donors. The World Bank and the OECD held a series of conferences which in 2005 led to the Paris Declaration on Aid Effectiveness. Donor countries will coordinate and harmonize their aid in order to effectively support their partners' national development strategies but those strategies will basically follow internationally agreed concepts of good governance to make them reliable participants in a global system of strengthening aid effectiveness. The results of cooperation are again evaluated in common. Although the Declaration explicitly integrates non-state donors into the quest for harmonization (it lists a number of CSOs as "participating organisations", for the follow-up process there is an *Advisory Group on Civil Society and Aid Effectiveness*"), it still has a rather conventional perspective by referring only to states on the receiving end ("partner countries"). Nevertheless, by explicitly addressing the problem of the multiplicity of donors related to the target of "delivering effective aid", it can be seen as the most advanced agreement reacting to the problem raised in this paper.

### *Effects in GHG*

Among most GHG actors, there have been serious concerns about the large number of heterogeneous actors and – as it is mostly seen – the resulting "inefficiencies in the global health architecture". We will, however, also have to take into account the advantages of flexibility and openness of an "open-source" system. (Fidler, 2007), which are frequently not considered in the effectiveness discourse.

In effect, the foundation of UNAIDS to coordinate activities in the fight against HIV/AIDS in 1995 can be seen as the starting-point of the search for coordination in the health sector. As explained above, however, it never really succeeded in coordinating UN actions. WHO re-created its HIV/AIDS department in 2001, and, thus, the creation of UNAIDS meant that there was just one additional actor in the fight against the disease. After the GFATM was set up, there were three different types of institutions, which ought to coordinate the fight against HIV/AIDS on the country level: national HIV/AIDS councils (supported by the World Bank), UNAIDS theme groups, and country coordinating mechanisms (CCM) of GFATM. Nevertheless, UNAIDS played an important role in organizing information and discourses on the disease and with its original mission, it was in a good position when coordination activities started again from 2003 onwards. Besides UNAIDS the *High Level Forum on the Health MDGs (HLF)* – three meetings in 2004 and 2005 – played an important role in dealing with aid effectiveness issues in health.

In the reaction to the demands for aid effectiveness, basically three issues were involved (World Bank/WHO 2006; OECD 2008) :

- (a) *The fight against HIV/AIDS*: Here, two main activities were promoted by UNAIDS: the concept of the "Three Ones" (2004) and the "Global Task Team" (in 2005). While the Global Task Team was a one-time stock-taking endeavour of delegates from relevant multilateral organizations, donor, recipient countries and CSOs and to improve coordination in the fight against the disease, the "Three Ones" are seen as a commitment towards a lasting improvement

of cooperation implying: one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners, one National AIDS Coordinating Authority and one agreed country-level Monitoring and Evaluation System (WB/WHO 2006: 15). Related to that, in 2007 a *Country Harmonization and Alignment Tool* (CHAT) developed by UNAIDS and the World Bank, was presented. Furthermore coordinating activities within the UN system concerning HIV/AIDS were strengthened in particular involving the UN Development Group which coordinates development oriented organizations within the UN system.

- (b) *The question of Global Health Partnerships* (GHPs) (HLF 2005) and Health Funding (Gottret/Schieber 2006, OECD 2008): The HLF developed “best practice principles for GHPs” based on a study commissioned to McKinsey&Co, basically demanding GHPs to adhere to the Paris Declaration principles, to establish an issue-oriented annual forum to be supplemented by more informal liaison and information-sharing between the 5-6 large GHPs. Concerning Health Funding (where GHPs including the GFATM play an important role), the non-alignment of funding with government priorities (50% is earmarked for specific diseases or programs), the lack of long-term support and the volatility of funding is criticized.
- (c) *Aid effectiveness in health at the country level and the support for national health systems* should in particular be supported by the establishment of the *Scaling Up for Better Health* (IHP+) Initiative, proposed by the HLF and started in January 2007: Following the example of the “Education for All – Fast-track Initiative”, key international health organizations, governments and private donors will cooperate to better use existing resources, create more effective mechanisms of accountability and to mobilize additional resources to support national strategic plans for health system development.

Obviously, the need for an improved coordination has been recognized by most actors in the GHG field and a number of initiatives have been taken. But what improvements have they brought about or can they be expected to produce in the coming years? Is there a risk that some of these initiatives will just lead to additional organizations as was the case with UNAIDS? There have been an impressive number of follow-up activities to the steps referred to above. UNAIDS (2007) talks about various common activities, but also pointed out that CHAT pilot projects in seven countries “reveal that the level of adherence to the Paris Declaration on Aid Effectiveness commitments by international partners is still too low” (ibid. 22f.). The GFATM in its most recent Result Report (GFATM 2007: 34) extensively refers to the Paris Declaration and develops respective targets (financing using country systems, avoiding parallel implementation units; predictability of disbursements, coordinated missions etc.) for 2010. The Paris Declaration has certainly hit an important need which is recognized by many GHG organizations. Though it is too easy for an evaluation of this process, it does not seem improbable that by producing a large number of new cooperative activities, it will contribute to an increase in complexity rather than a decrease. However, as long as this contributes to a denser web of networks that might not hamper the further development of the global governance of aid, but might leave space for flexibility important for political processes beyond the field of aid.

Interestingly enough, while there has been much discussion on raising additional resources and on effectively spending them, the question of prices of medicines were hardly raised in this context, though the saliency of this question must have been clear after the experience with ARVs for treating HIV/AIDS (prices falling in poor countries from about \$10.000 for treating one patient for one year to between € 150 and 500 with obvious consequences for the resources needed for AIDS treatment) and with continuous conflicts on IPRs and the use of compulsory licenses to allow access to medicines.

### *Problems*

Quite clearly, the Paris Declaration constitutes an attempt to reproduce order in a system of global governance. By focussing on the role of states as partners of development cooperation, it does not,

however, respond to the specific logic of transnational non-state actors and basically ignores the question of *policy coherence* with respect to developed countries interests and the interdependence of different fields of global governance. Without intending that, the Paris Declaration effectively creates a step towards global statism as it uses primarily the logic of state organization to tackle problems of coordination (with a view of empowering developing countries to act as partners at eye level).

This, however, leaves open the question of how the aims of aid effectiveness and policy coherence on the global level could effectively be linked. A paper by Robert Picciotto (2004: 5) highlights the problem of aggregating “the preference functions of diverse groups ...without ambiguity”. He refers to a list of examples of “potential policy incoherence” and to the role of CSOs. As a former Director General of the World Bank Evaluation Department (1992-2002) certainly not suspect of being a radical NGO activist, Picciotto points out:

‘As part of the grand debate on globalization, civil society organizations have played a leading role in sensitizing public opinion with respect to the development incoherence of OECD policies. They have also helped to mobilize political support for specific policy reforms. In 1994, an NGO campaign decried the impact of European beef export subsidies on West Africa’s rural welfare. In 1996, NGOs lobbied against a fisheries policy that allocated fishing rights and subsidies without regard to the impact on the coastal fisheries of developing countries. A year later a proposed lift of the ban on cocoa butter alternatives faced strong opposition from development NGOs.

Similarly, the Highly Indebted Poor Countries debt relief initiative would not have been born without the Jubilee campaign. More recently, the international trade agreement on generic drugs in the run up to the Cancun meeting would not have materialized without the skillful work of major advocacy NGOs. No reform of OECD agricultural trade and subsidy policies is likely without continued, evidence-based civil society activism.

Equally, with respect to foreign direct investment, NGOs are likely to remain instrumental in sustaining the momentum of the corporate social responsibility movement and the harmonization of social and environmental safeguard policies by international development and commercial credit and guarantee agencies’. (Picciotto 2004:5)

I include this long quote as it highlights aspects of policy coherence that actually are not stressed in most criticisms of the Paris Declaration by NGOs referring in this context – correctly, as well – to the questions of effective national ownership in developing countries and to the lack of consideration for the role of civil society in these countries (for example: Reality Check 1/2007; Drescher 2006). In all the cases referred to by Picciotto, however, CSOs contributed to policy coherence just by *not aligning* themselves with forms of policy coordination dominant at that time. In addition it is important to realize that the issue of policy coherence (like all these examples) refer to the problem of *conflicts* between different policy fields, while most of the attempts at global coordination take place within a certain policy field.

How can this problem be solved? During the last years so-called “whole of government” approaches have found increasing attention, which integrate all departments concerned into policy-making processes. This again refers to coordination within specific *governments*<sup>2</sup>. Transferring it to the level of global governance would imply a coordination of inter-and transnational policies in specific policy fields and a “whole of *governance*” approach for creating policy coherence. One should not forget that we are not talking about the coordination of actors with basically common interests and common strategies to pursue their interests. Thus, in order to achieve reliable solutions to global problems and a minimum of compliance of the actors involved to play the role ascribed to them in this coordination game, there is an inbuilt tendency towards a quasi-bureaucratic and increasingly global coordination, which imply some kind of global statism.

A strategy towards a “coordinative holism” as one might call such an approach, necessarily needs some fixed points of reference: Concerning “coherence”, this implies the assumption that actors will

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<sup>2</sup> As Picciotto (2004:5) formulates „Such an approach requires transparent information links among individual departments as well as strong leadership and transparent linkages between the specialized units and the sovereign body.”

be ready to subordinate their specific interests to some overarching goals supported by all actors concerned (like “development” or “poverty reduction”). Concerning policy coordination, it is assumed (a) that cooperation partners set an agenda which is not in conflict with basic interests of donors (for example, economic liberalization and effective IPRs) and (b) that systems of accountability do work. Partners commit, to “make progress towards building institutions and establishing governance structures that deliver effective governance public safety, security, and equitable access to basic social services” (Paris Declaration, Art. 38). This is close to a definition of “development”, so “development” is a pre-condition for receiving coordinated aid for development – which should be understood as a positive feedback process, but also includes an aspect of circular reasoning

In effect, trying to coordinate activities and to create coherence without adequate mechanisms to take binding decisions on solving conflicts between different actors means producing new forms of bureaucratic activities which create expectations which they cannot fulfil. This also means, by trying to *harmonize* activities of a multiplicity of donors (create “common *arrangements*”), it implicitly reduces the flexibility inherent in an “open-source” anarchy in a globalizing world society, where new actors can instantly react to specific problems. These, in fact, might not solve the need for coordination, but they can contribute to a system of networked activities which relate to existing conflicts among states *and* transnational actors.

## **(6) The potential of international/world commissions**

Commissions, networks, working groups, advisory groups etc. play a role everywhere in politics linking civil society and stakeholders to the political system. They also play an important role in the processes towards “policy coherence for development” and “coordination for aid effectiveness”. I suspect, however, that they are even more important where they are not immediately linked to coordination processes within and between governments and intergovernmental organizations, but are free to take up various old and new concepts, to refer to existing conflicts and to propose innovative solutions.

I am referring here to high-level/world commissions, which have been established on a number of important issues. They mostly *consist of members representing stakeholders of a quite diverse political and cultural background, which are established for a limited period of time to produce a substantial report on a topic of far-reaching importance*, in general supported by a budget which allows “commissioning” the production of a large number of papers produced by experts to shed light on many different aspects related to the central task of the respective commission. International high level commissions have a rather long history; some of them undoubtedly had an important impact at least on discourses in the field of global governance (like the so-called Brandt Commission, the Brundtland Commission, the Commission on Global Governance and some more). In fact, there exist a huge number of studies on specific cases, but little scientific research on the phenomenon of the “international high level commissions” as such.

In the context of this paper I will only refer to three such commissions which have been initiated and managed by WHO and have proven the importance of this tool of communication and coordination, but have also shown significant differences depending on the issue they dealt with: the Commission on Macroeconomics and Health (CMH), the Commission on the Social Determinants of Health (CSD) and the Commission on Intellectual Property Rights, Innovation and Public Health (CIPRH), on which I will focus. These commissions have turned out to be important tools of policy-making that can help coordinating the multiplicity of actors also in GHG, leading to influential policy recommendations and possibly to results being channelled into international negotiations about binding agreements.

### *Inclusive forms of problem solving*

The Commission on Macroeconomics and Health (CMH) was launched by WHO Director-General Gro Harlem Brundtland in January 2000 and headed by Harvard professor Jeffrey Sachs. In the resulting *Report on Macroeconomics and Health*, "health" is seen not just as a component of development, but as a basic pre-condition for economic growth itself. The report, presented in December 2001, played an important role in raising public consciousness about the need for a massive scaling-up of health financing and strengthened support for the GFATM, established just a few months before, and health-financing by private foundation for global health partnerships (Seidel 2003).

The Commission on the Social Determinants of Health has been established in March 2005, to analyse the equity dimensions of health inequality and the social context of health with respect to the social conditions that lead to illness as well as concerning the need to make health systems more responsive to the needs of the socially disadvantaged. This Commission as well brings together leaders from politics, academics and civil society and bases its work on a large number of background papers which are produced and discussed by thematic knowledge networks. They are available in the internet ([http://www.who.int/social\\_determinants](http://www.who.int/social_determinants)) and have already contributed to academic discussions (see: WHO 2007, Labonté/ Schrecker 2007). The Commission's final report will be presented at the World Health Assembly in May 2008.

Politically most interesting are the context and the results of CIPIH set up in 2004. It builds on years of conflicts on intellectual property rights and access to drugs as summarized above. And it stresses the legal obligations: In its General Comment No. 14, the UN Committee on Economic, Social and Cultural Rights (CESCR) emphasises that the right to "the highest attainable standard of physical and mental health" formulated in the International Covenant on Economic, Social and Cultural Rights (article 12.1) obliges member states to make available those drugs that are indispensable (as stipulated in the WHO list of essential drugs). Following the final report of CIPIH (2006) there was a general recognition of the need for changes in the global system of innovation on drugs. The World Health Assembly of May 2006 discussed a "Global Framework on Essential Health Research and Development" (drawing strongly on concepts proposed by the US-based CSO Consumer Project on Technology, cp-tech) and established the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property under the auspices of the WHO with the mandate "to prepare a global strategy and plan of action on essential health research to address conditions affecting developing countries disproportionately". The three Commissions, but CIPIH in particular, have demonstrated the capacity of such commissions to allow an open discourse between stakeholders with conflicting interests and to produce a meaningful focus for strategic debates and decision-making of participating organizations. Specific departments of intergovernmental organizations – like the WHO department on Trade and Health – do not only provide the infrastructure for such a commission, but are developing nodal functions regarding specific issues of GHG. Continuously operating mechanisms (like a "Committee on Health and the Private Sector") which coordinate basically autonomous actors can work in a rather unbureaucratic way if they coordinate the use of resources contributed by each of the participating actors. On the other hand they can refer problems which need decisions by state authorities to the World Health Assembly.

### *Linking results to law-making processes*

The new round of negotiations on concepts for funding of health research on the one side and the evolving norm of "universal access to essential medicines" points to the consolidation of new institutional forms in GHG. Certainly, intergovernmental agreements continue to play an important role for establishing binding rules. Nevertheless, state actors are also becoming part of a more open field of global politics in which various types of non-state actors (CSOs, TNCs, GPPPs, philanthropic

foundations) are strengthening their position and creating a complex field of interfaces. Private companies and CSOs are now playing a more open role in pushing for legal agreements, for amendments, or authoritative interpretations of existing rules, as has been analyzed for the conflicts around TRIPS. In some GHG institutions, such as GFATM and in GPPPs, private actors are having voting rights and are playing an important role as experts, as well as strong advocative actors and lobbyists for their own interests.

## **(7) Conclusions**

Since the early 1990's, a large number of new actors have emerged in the international health landscape to respond to new challenges and fill gaps left unattended by older institutions. Nevertheless, the transformation of health into a global issue with an increasing number of actors involved had important consequences:

1. It created a growing consciousness of global responsibility for global health, which – though it does not easily translate itself into a coherent system of resource transfers – helps to mobilize resources through the multi-faceted system of global health governance.
2. GHG (and in particular CSOs) will put pressure on governments which for whatever reasons do not give a high priority to financing inclusive national health systems (or are developing some specific idiosyncrasies such as the South African government with respect to HIV/AIDS).
3. So far, the complexity of GHG actors makes it quite difficult for national health systems to make an efficient use of the resources transferred by dozens of different foreign organizations, with sometimes conflicting perspectives and concepts. All these organizations demand the attention of local administrations, demand reports and, as a whole, create a flexible but chaotic systems.
4. In this context, by initiating and hosting important global high level commissions, the WHO, as a broadly legitimized international institution, has begun to use the chance of structuring discourses on the “source codes” of global health governance and of linking them to institutions of international law making.
5. The Paris Declaration has evoked manifold attempts to improve coordination in GHG. It certainly has played an important role in stressing the need for an improved national coordination and an improved financing of national health systems (as the hardware of GHG). Whether it will really succeed in a coordination of activities of the myriad of actors is questionable, and the author is not sure whether this would be really desirable due to the important role of advocacy networks in global health conflicts.

Institutional anarchy is a result of a historical situation, in which the role of the nation state in producing social order has been challenged by globalization, reducing states' capacity to govern economic and social integration on the national level and opening up spaces for the participation of transnational private actors in governance processes. Coordination which seeks to limit these spaces might result in some short-term successes but will not be able to govern the more long-term needs of social and political change. More open forms of coordination based on flexible networks (which do not preclude a stronger political control, where it is necessary, e.g. in the development of health systems) might be more useful to deal with conflicts which transcend sectoral borders and which might lead to more coherence in the development of a global society.

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