Chapter 5
The New Dynamics of Global Health Governance

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Reader's Guide

This chapter considers the impact of globalization on international health policies and the emergence of new approaches to **Global Health Governance** (GHG). The first part of the chapter describes the changes in institutional structures since the 1990s that have had a fundamental impact on GHG. These structural changes have occurred as the discourse on trans-boundary health has broadened and engaged more public, private and voluntary sector actors in the debate. This has brought greater recognition of the need to mobilize a range of financial and other resources and to adopt a more flexible approach to problem solving. But the proliferation of public and private actors has also brought greater complexity that could inhibit the effective application of these resources and solutions.

The second part of the chapter discusses ways of improving the coordination, **accountability** and legitimacy of GHG while preserving the engagement of non-state actors and the ability to respond flexibly to global health challenges. In particular it explores the concept of nodal governance and its implications for the role of the World Health Organization (WHO) in the new dynamics of GHG.

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Learning Points

- The definition of GHG.
- The impact of globalization on health.
- The triangle of GHG.
- The rise of new actors in global health and its governance.
- The importance of open transnational networks and nodal leadership for the engagement of all actors in new forms of global governance for health.

Introduction: Global Transformation and Health

The term **global health governance (GHG)** did not appear in global health discourse before 2002 (Dodgson et al. 2002), but since then it has become a sort of buzzword. Whatever its precise definition (see Box 1), it obviously reflected a change in international health politics which demanded a new term. Since the mid-1990s the number of public–private partnerships (**Global Health Partnerships**) established to deal with specific international health problems has grown rapidly. New actors became increasingly important in financing global health activities including organizations such as the Global Fund. These new actors often developed structures and processes which were significantly different from classical intergovernmental organizations (IGOs) due to their highly focussed **results oriented** approach to single issues. In addition, one of the fiercest conflicts in global health, concerning the TRIPS agreement and access to medicines, unfolded with WHO playing only a marginal role. The leading role of WHO had been challenged.

All three definitions in Box 1, whether explicitly or implicitly, refer to a plurality of actors, processes and regulations which operate in a contested arena and produce health policy outcomes as a result of activities which are not coordinated by conventional institutions. Within a few years, the post-war architecture of international health seemed to have been overturned.

What has led to this change and what does it mean for the future of global health? The rise of GHG is closely linked to the process of globalization (Lee et al. 2002),

Box 1 Defining Global Health Governance

"Global governance for health describes the structures and processes through which the global health issues are addressed" (European Perspectives on Global Health. A Policy Glossary, Brüssel 2006, p. 35).

GHG is the "totality of collective regulations to deal with international and transnational interdependence in the context of health issues" (Hein/Kohlmorgen 2008, p. 84).

(continued)

Box 1 (continued)

"For us GHG is viewed as a contested space which is much broader and deeper than current scholarship acknowledges. Instead of existing in a separate sphere to globalisation, we view GHG as immanent in the critical processes of globalisation and marked by sharp divisions in policy and competing worldviews of global health which have not yet settled or reached an identifiable conclusion" (Kay and Williams 2009, p. 3).

understood as an intensification of cross-border flows of goods, services, finance, people, and ideas. **Globalization** has been facilitated by new technologies and by changes in the institutional and policy regimes at the international and national levels, for example by the promotion of trade liberalization (Held et al. 1999). It extends far beyond the economic realm to political, cultural, environmental, and security issues and implies an increasing transnational interconnectivity of people and communities, leading to a growing density of transnational social relations and the creation of common identities based on characteristics other than nationality—for example among people in civil society networks fighting for justice in global health. Globalization has increased the need for inter- and transnational cooperation to "govern" the many global forces that can effect human health. Yet, in the absence of a central political authority beyond the nation state, there are multiple sets of often conflicting rules and norms. How can the interaction of these rules and norms be resolved? How can relations of legitimacy and **accountability** be established when the *demos* is spilling over beyond the territorial foundations of democratic rule?

Globalization has had important consequences for the dynamics of global problems such as health as well as on the architecture of international relations, as summarized in Box 2:

Box 2 Globalization and Health

- *Health threats* such as HIV/AIDS, influenza, SARS or avian flu threaten every country and the global community as a whole due to the rapid spread based on global travel and mobility; their impact is frequently very serious in economic terms.
- The *globalization of lifestyles* has led to common chronic disease challenges such as diabetes and is linked to the impact of global industries such as tobacco and alcohol as well as the food industry.
- The health sector is a *critical sector for stability* in many countries, health-care financing is a key political issue in all countries; the mobility of patients and health-care professionals is a global issue

(continued)

Box 2 (continued)

- Health is *one of the largest industries worldwide*, critical issues—for example around intellectual property and trade in goods and services—have major economic consequences for companies and countries, and major consequences in terms of access for poor people and countries. The access issue has gained large attention in particular concerning access to anti-retrovirals (ARVs) and the conflicts related to the TRIPS Agreement and the production and marketing of generic versions of medicines.
- *Inequality of access to health* around the world is gaining more attention and has become a major subject of discourses on human rights and social justice, more investment in health is critical for all nations, especially the poor. Inequality (and the immense resources needed for global redistribution) can be roughly characterized by the gap between annual health expenditures per person of $7,285 in the USA and less than $10 in Myanmar, Eritrea and Ethiopia (World Bank data, http://data.worldbank.org/indicator/SH.XPD.PUBL).

The dynamics of global governance can be understood as a reconfiguration of political actors in dealing with new forms of global problems, which have turned out to be difficult to handle by any one of the three main types of actors in global politics (see Fig. 5.1) for a variety of reasons:

(a) The increasing urgent need to deal with global problems which are *beyond the control of national governments*.
(b) The limited capacity of most **IGOs** to intervene effectively in *trans*national affairs, due to a lack of resources and a limited flexibility for cooperation with non-state actors, but:

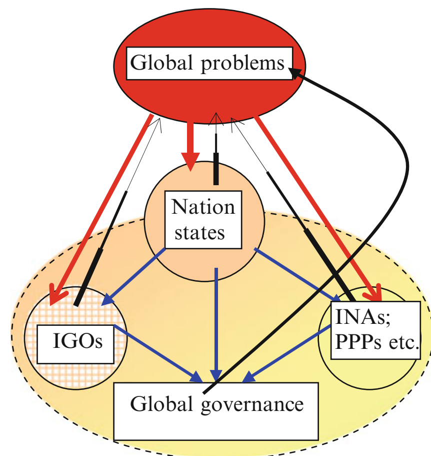

Fig. 5.1 The triangle of global governance. *Source*: W. Hein

(c) While strong efforts by nation states and IGOs frequently led to little or no effect on problem-solving, it has been increasingly easy for **international non-state actors (INAs)** to operate in the transnational space and—due to (a) and (b)—their contributions have generally been welcome within the relevant policy field. Global governance has developed as a field of cooperation and compromise between an increasing number of actors concerned, whereby in many cases—though certainly not always—conflicts which, seemed to be paralyzed, could be resolved.

Global Health Governance: New Challenges and New Constellations of Actors

Three examples are helpful to understand the flexibility allowed by the new openness of global governance structures:

1. The trends towards globalization and economic privatization supported, for example, by the creation of the World Trade Organization (WTO), have reduced the independent capacity of states and IGOs to fight global diseases. As an alternative, **GHPs** have been proposed and founded to integrate a number of different actors in different combinations as required by the specific tasks and the social and political environments. Flexible forms of cooperation became possible which combine the specific needs identified by governments, IGOs or **Civil Society Organizations** (CSOs) with the scientific and technological capacities and economic interests of private corporations and the financial resources of donor countries, public funds or private foundations. During recent years, GHPs made important contributions to research on neglected diseases, to finance health activities in fields like HIV/AIDS and immunization and to improve access to medicines in poor regions (see "Global Health Governance: New Challenges and New Constellations of Actors" section on GHG actors).
2. The zero-growth strategy imposed on the budget of many UN organizations by the USA (but also supported by other high-income countries)—basically an expression of hegemonic conflicts—significantly reduced the governance capacities of WHO: The so-called United Nations Reform Act (Helms-Biden Act, a 1999 US law) set a number of conditions for the reform of the UN system before the USA would even release its total amount of arrears in payment to the UN. The principle of zero nominal growth forced WHO to raise extra-budgetary resources which are mostly ear-marked for specific projects and reduce the budgetary autonomy of the organization.

   Nevertheless, since the end of the 1990s US contributions to global health experienced unprecedented growth. The US strongly supported the G8 initiative to create a fund to finance the global fight against HIV/AIDS, tuberculosis and malaria—provided the fund would not be managed by a UN organization. Thus, an independent fund was established, based on the PPP model (state governments,

representatives of private enterprise and civil society organizations as decision makers; IGOs like WHO and the World Bank included only as non-voting members of the Executive Council). Furthermore, the US government created bilateral channels to make important contributions to global health, in 2003 *PEPFAR, the President's Emergency Plan For AIDS Relief* committed $15 billion for 5 years to the fight against HIV/AIDS; and $63 billion over 6 years to the 2010 Global Health Initiative "to improve health outcomes". In addition, contributions to global health by US private foundations (in particular, the Bill & Melinda Gates Foundation) increased rapidly and since 2006 more or less equal the level of the WHO regular budget.

3. The high prices of anti-retroviral medicines, made possible by the internationalization of intellectual property rights in the TRIPS agreement, turned out to be a major barrier to realizing the human right of universal access to essential medicines. The UN Committee on Economic, Social and Cultural Rights (CESCR), emphasized in its General Comment No. 14 (2000) 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).

   In addressing this challenge, it was not only the pressure of civil society organizations for access to medicines but also the response of transnational pharmaceutical companies in selling medicines to poorer countries at reduced prices or to allow generic companies to supply markets where they held patents that were vital. There were also a large number of financing initiatives (such as the GFATM, internationally operating foundations, and various NGO and church initiatives), as even with reduced prices, many poor countries need additional funding to finance AIDS treatment (Hein and Moon 2013). These concrete processes made it possible to significantly expand access to ARV therapy for people living with HIV/AIDS and to expand the "access norm" to include medicines beyond ARV drugs (e.g., for heart disease & cancer).

The rise of new actors has not only contributed to a higher degree of flexibility in dealing with global health problems but also added expertise and financial resources (Fig. 5.2). While the contributions of traditional state actors (bilateral and multilateral agencies) grew from $5.1 billion in 1990 to about $18.1 billion in 2007, i.e. by a factor of 3.5, during the same period the contributions of non-state and hybrid institutions grew nearly 15-fold (from about $0.6 billion to about $8.8 billion).

Most of the changes in international health politics discussed so far were focussed on mobilizing support for developing countries in global health. However, the WHO was not created to be a development organization, but to "act as the directing and co-ordinating authority on international health work" (Constitution of the WHO, Art. 2a). This implies the provision of global public goods, e.g. securing access to vaccines, eradicating a virus or enforcing rules to prevent the spread of infectious diseases or of unhealthy consumption habits. For decades, WHO had been very reluctant to launch initiatives concerning international treaties in the field of health (in contrast to the very different attitude of ILO in this respect). The negotiation of

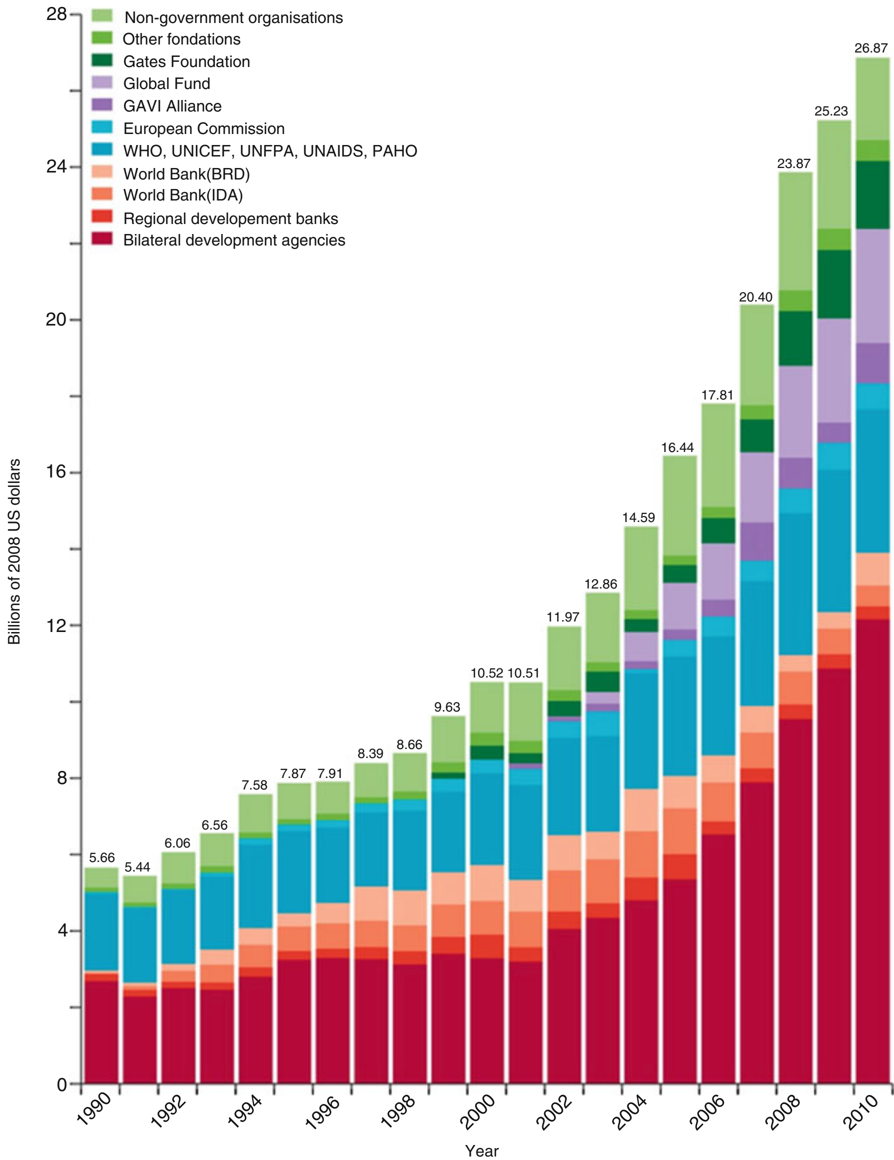

Fig. 5.2 Development assistance for health from 1990 to 2010 by channel of assistance. *Note*: The *bar chart* represents the contributions of specific (groups of) donors in the same sequence as in the legend (*BMGF* Bill and Melinda Gates Foundation, *GAVI* Global Alliance on Vaccines and Immunization). *Source*: Murray et al. (2011, pp. 8–10)

the *New International Health Regulations* (IHR 2005) and the *Framework Convention on Tobacco Control* (FCTC) can be seen as an indication that WHO has also felt the need to respond to the changing global environment, in particular to the increasing needs for the regulation of global public goods for health.

The negotiation of these agreements points to the need to involve Nation states in the politics of global governance: Only states can make internationally binding rules. While in many other fields of global politics, the principle of subsidiarity might apply, strengthening the role of private actors and "reducing" states to just one type of actor among others, there is no way of creating legitimate, universally binding rules other than through agreement between states. Nonetheless, the growing involvement of a globalizing civil society might make it easier for state governments to overcome power-based interests in favour of issue-focussed solutions, in the negotiation and implementation of agreements. Non-governmental organizations played an important role in the intergovernmental negotiating body for the FCTC and the Tobacco Free Initiative (with a strong participation of CSOs) supporting the implementation of the Convention.

It is also notable that in the event of a "Public Health Emergency of International Concern" the new *International Health Regulations* grant the WHO far-reaching powers and non-governmental organizations are assigned key roles (Fidler 2005). The WHO has the right to require member states to develop appropriate capacities for monitoring possible international health risks. It can, however, also use non-governmental information sources and, if necessary, issue recommendations for the restriction of travel and trade without the consent of the state concerned. The WHO led Global Outbreak Alert & Response Network includes the contributions of UNICEF, UNHCR, the Red Cross, non-governmental groups like Doctors without Borders and scientific institutions within member states.

Self-organization Through an "Open-Source Anarchy" or Need for More Coordination and Guidance?

The discourse on GHG points to the importance of new types of actors and the growing importance of non-state actors in global health affairs. But what is actually new? The history of international health is full of non-state actors. In colonial territories, hospitals built by Faith-Based Organizations (FBOs) introduced modern health care in areas beyond the capital or port cities. The International Committee of the Red Cross was founded in 1863 very consciously in the form of an international institution to coordinate decentralized, non-state relief societies to stress the neutrality of medical services in armed conflict (Bugnion 2009). It is also relevant to note that the Rockefeller Foundation financed up to 50 % of the budget of the League of Nations Health Organization.

Nevertheless, most observers of GHG agree on a number of characteristics that are specific to the last 10–15 years of institutional developments in international health:

1. A great proliferation in the number and variety of health actors.
2. Increasing interdependencies between health and other areas of global governance (trade and intellectual property rights; environment; agriculture).

3. A growing impact of CSOs.
4. A growing importance of private funders (e.g., foundations).
5. New types of hybrid actors and global initiatives (e.g., foundations, Public–Private Partnerships, the Global Fund to Fight AIDS, Tuberculosis and Malaria, GFATM) interact with national governments and international governmental organizations.
6. GHG implies a substantive concern with issues that affect populations worldwide directly (for example the global spread of disease, such as HIV/AIDS and the much-feared new pandemic influenza) or indirectly (extreme inequalities in medical care, unhealthy consumption patterns). The Millennium Development Goals (MDGs) (proclaimed in 2000, including goals of fighting infectious diseases and improving maternal health, child mortality and access to medicines) and the Commission in Macroeconomics and Health (WHO 2001) are expressions of this concern.
7. To a greater extent, poor health is not only seen as a consequence of poverty but also as a cause of lack of development; investments in health are seen to offer value for money through their positive impact on development.
8. Cooperation in international health is no longer solely "governed" by state actors or inter-governmental agencies such as the WHO.

GHG can be understood as a mechanism for collective problem-solving, i.e. health improvements through the interplay of different institutional forms and actors at different levels. All of this points to a form of GHG, characterized by a polycentric, distributed structure and a substantive focus on issues that affect populations worldwide, directly (for example the global spread of disease) or indirectly (through extreme inequalities). It now requires management not merely of specific transborder epidemics but of the host of issues that arise in health at the intersections of a globalized economy and individual lives in particular localities (Hein et al. 2009).

Depending on the vantage point, one can see GHG as an anarchy of actors which constitutes a "creative plurality" in managing global health (at every moment raising new health issues and proposing new ways of solving them), or as waste of material and political resources through the uncoordinated fragmentation of actors and activities. Figure 5.3 illustrates the range of actors in global health according to the public–private dimension.

During recent years the numbers of hybrid organizations (GHPs and GHIs) and private actors have considerably increased. The **interconnectedness** of different organizations is by far too great to be displayed here in a meaningful way. Though there can be hardly any doubt that the number and intensity of links has grown considerably since earlier decades, a large number of inter-organizational relationships already existed in the 1950s and 1960s. What can be assumed as a qualitatively new phenomenon—in correspondence with much of the globalization literature and many accounts from GHG processes—is the high volatility of organizational patterns and institutional change and the flexible reaction of Global Health actors to new challenges. Regrettably there are few systematic analyses of the dynamics of these networks in GHG.

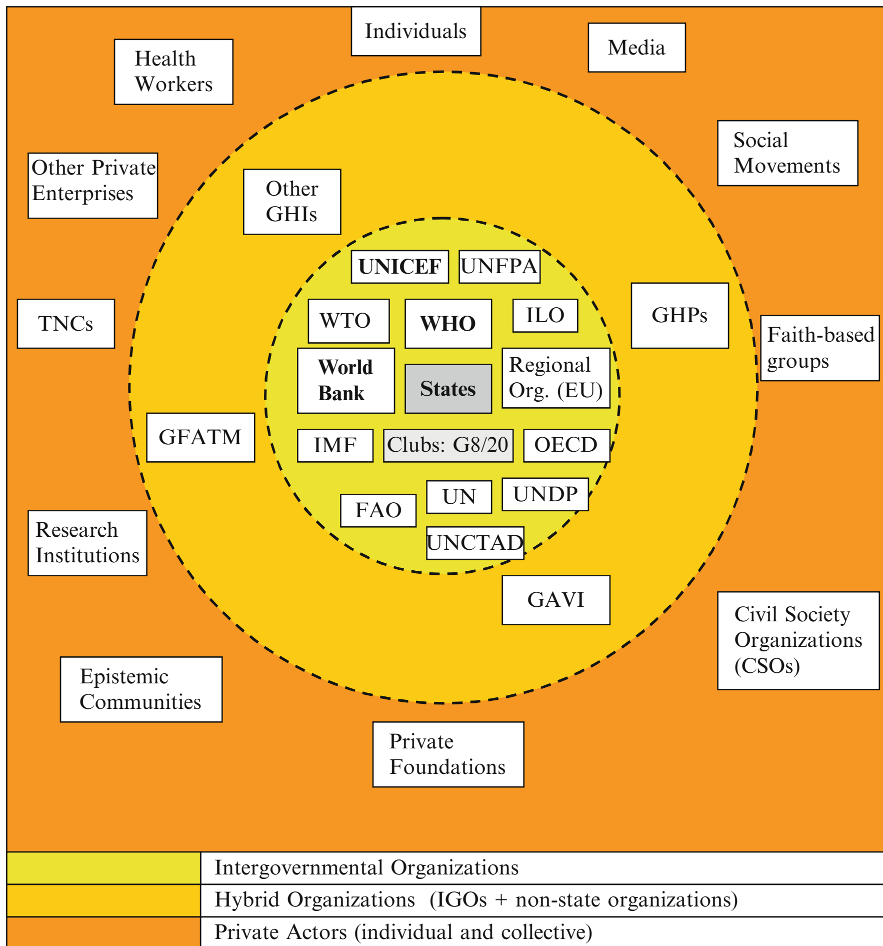

Fig. 5.3 Actors in global health. Abbreviations (besides well-known UN organizations): *GHIs* Global Health Initiatives, *TNCs* Transnational Corporations, *GAVI* Global Alliance for Vaccines and Immunization, *UNFPA* United Nations Population Fund. *Source*: W. Hein

David Fidler characterized the GHG system as a form of "**open-source anarchy**", which is broadening and deepening the normative basis for global health action (2007: 9f.). "Anybody can access, use, modify and improve" (2007: 9f.) similar to open-source software. This means that the interactive space of relations between national societies is no longer dominated by inter-state relations. Transnational relations are not squeezed into diplomatic rules and traditional means of exerting pressure on other states by the application of power politics or through the complicated mechanisms of international organizations. Actors can use their specific strengths to reach their goals (financial and expert resources, discourses and using them to mobilize support, including influence on the process of international law-making). **Transnational networks** between health-oriented actors have been

formed that focus on specific issues (like access to medicines, neglected diseases, and tobacco control) constituting a complex web of global social relations related to the issue of global health.

Jean-Michel Severino and Olivier Ray (2010) discuss similar changes in the field of development aid (which is in part linked to GHG): the surge of an "institutional jungle" and a tendency towards the privatization of international cooperation. They propose the term "hypercollective action" to characterize this "new mode of production of global policies" (Severino and Ray 2010:11). They acknowledge not only the mobilizing and creative dimension of this mode but also the "considerable costs in terms of efficiency, time, coherence and … credibility" (Severino and Ray 2010:12). This leads straight to the points made by the critics of the advocates for effective self-organization through an "open-source anarchy":

1. International cooperation is becoming more complex. Poor countries are receiving aid from a growing number of different organizations. This has made it difficult for national governments to stay in control of their own health systems or to effectively allocate aid.
2. Most of the new non-state actors in GHG can be accused of a lack of **legitimacy** and **accountability**. Large CSOs, GHPs and financially strong foundations (like the BMGF) are having a great impact on global health without being accountable to people affected by their activities. While IGOs might also have legitimacy problems, they are clearly accountable to governing bodies in which sovereign states are represented.
3. GHPs are not necessarily identified with vertical strategies focussed on specific diseases, but their targets are mostly linked to a chain of activities focusing on controlling and treating specific diseases including the identification of pathogens, research and development of medicines and means of treatment, distribution of medicines, securing access (finance, technical infrastructure) and the medical infrastructure for treatment. Horizontal activities like improving national health systems and developing systems of primary health care have been relatively neglected.

Whether the characteristics of GHG are seen from a more optimistic or a more critical perspective, "coordination" has become a major focus of discussions of the future of global health. The need for better coordination is certainly recognized in, first, the processes of assessing health needs and strategies to deal with them; second, the search for more systematic institutional mechanisms for improving coordination and third, the attempts to strengthen legitimacy and **accountability** by engaging multiple forms of networking in the agreed processes for taking important decisions.

Discursive Processes in GHG

It is generally recognized that the broadening and deepening of discursive processes in GHG has contributed significantly to the growth of public attention and strengthening of support for global health action, as well as to the constructive processes of conflict resolution. The open-source character of GHG has facilitated the articulation

of the concerns of very different constituencies (human rights movement, different "publics", expert networks, etc.). Examples of open discursive processes have included the International AIDS Conferences, the Global Forum on Health Research and **Global Expert Commissions** on urgent topics. The power of broader discourses can be contrasted with political power processes: while political processes can release the public sector resources required to address problems in a conventional way, discursive power can find new solutions and call on a wider range of public and private resources. Discursive power (particularly if magnified by mass media) can also put pressure on actors with political and economic power and resources.

World commissions have been established on a number of important issues in global affairs. They *consist of members representing stakeholders of diverse political and cultural backgrounds and charged with producing a substantial report on a topic of far-reaching importance,* supported by a budget which allows them to fund the production of expert papers to shed light on the respective topic from various perspectives. Famous examples are the so-called Brandt Commission on International Development, the Brundtland Commission on the environment and development and the Commission on Global Governance which examined the social determinants of health.

Three such commissions were initiated and managed by WHO. These have been important mechanisms for policy-making, serving as fora for communication between stakeholders with conflicting interests. They played an important role in coordinating the contributions of the multiplicity of GHG actors and to focus the international discourse on specific issues.

Box 3 Expert Commissions on Global Health Issues

The *Commission on Macroeconomics and Health* (*CMH*), 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 (WHO 2001), played an important role in raising public consciousness about the need for a massive scaling-up of global health financing.

The *Commission on Intellectual Property Rights, Innovation and Public Health* (*CIPIH*),set up in 2004: It responded to years of conflicts on intellectual property rights and access to drugs. Following the final report of CIPIH (WHO 2006) there was a general recognition of the need for changes in the global system of innovation in drug development and access to strengthen research on neglected diseases and to improve global access to essential medicines. It was recognized that support for innovative capacity in developing countries was an important way to reach these goals.

The *Commission on the Social Determinants of Health*, established in 2005: Its task was to analyse the causes and consequences of health inequality and the social conditions that cause illness as well as the need to make health systems more responsive to the needs of socially disadvantaged people. The Commission's final report was published in May 2008 (WHO 2008).

The CIPIH demonstrated the capacity of such commissions to produce a meaningful focus for strategic debates and to channel their results into international negotiations. The World Health Assembly (WHA) discussed in 2006 a "Global Framework on Essential Health Research and Development". In a resolution passed in May 2008, a *Global Strategy,* and parts of the corresponding *Plan of Action* were adopted (WHA 61.21). The WHA 2010 discussed ideas for financing this strategy; the *Taskforce on Innovative International Financing for Health Systems* estimated that by 2015, US$7.4 billion annually will be needed to fund health research and development.

Today, transnational discourses on health are highly important in raising issues, setting agendas and defining the terms in which problems debated in IGOs and in other international fora are understood by the public and by important political actors. They are also crucial in providing a structure and processes to shape the dynamics of transnational communication. They transform the formerly rather thin and simply structured flows of international communication between governments and a few other actors into a dense web of exchange.

The Paris Declaration: Coordinating Policies?

Following the adoption of the MDGs in 2000, OECD and the World Bank organized a global discourse on the effectiveness of development cooperation, leading to the *Paris Declaration on* ***Aid effectiveness*** (2005). The Declaration specified five target areas for improving aid effectiveness: ownership, harmonization, alignment, results, and mutual **accountability**. Donor countries agreed to coordinate and harmonize their aid in order to support their recipient country partners' national development strategies. These development strategies will reflect national needs and priorities while recognizing internationally agreed concepts of good governance. In preparation for the *Accra High Level Forum on Aid Effectiveness* (a 2008 follow-up meeting to the Paris conference in Accra, Ghana), the WHO, the World Bank and OECD proposed to use the health sector to track progress on the Paris Declaration: "Aid effectiveness is particularly challenging in health. As with other sectors, difficulties are the result of inefficiencies in the global aid architecture and of poor country policies; however, problems in health are exacerbated by the inherent complexities of the sector itself" (http://www.oecd.org/dataoecd/14/37/42254322.pdf). Global Health is affected by the Paris–Accra-Agenda whenever country level coordination is at issue.

UNAIDS promoted the "Three Ones" (2004), aimed at establishing: one agreed HIV/AIDS Action Framework for coordinating the work of all partners; one National AIDS Coordinating Authority and one agreed country-level Monitoring and Evaluation System (World Bank and WHO 2006, p. 15). The *High Level Forum (HLF) on the Health MDGs* (World Bank and WHO 2006) held three meetings in 2004 and 2005. "Scaling up aid for health" was the HLF's main target, which called for a better coordination between GHPs, the improvement of health funding and

concrete strategies to support the development of health systems in poor countries. The lack alignment of HIV/AIDS funding with government priorities, the lack of long-term support and the volatility of funding was criticized.

The *Scaling Up for Better Health (IHP+) Initiative* established a network of cooperation between the most important health funders. The IHP+ process is led by the so-called Scaling-up Reference Group (SuRG), which brings together the eight most important agencies/initiatives in global health, WHO, World Bank, GAVI, UNICEF, UNFPA, UNAIDS, the GFATM, and the Gates Foundation, which under the name "Health 8", has gained importance beyond IHP+. The focus of all IHP+ initiatives is on achieving health-related MDG outcomes through efforts to increase aid effectiveness, improve policy, strategy and health systems performance, and also a broad mobilization of non-State actors.

Thus, the **Paris–Accra Process** has led to a number of interactive processes for GHG by strengthening the links between the activities of different actors and national decision-making institutions, and improving aspects of accountability and legitimacy. However, this only marginally affects processes of agenda-setting and health policy making at the global level. There is a lack of institutional structures and processes to support continuous interaction between the myriad processes of local, national and international decision making on global health issues and the processes for formulating binding norms and rules for GHG.

Making WHO Fit for Nodal Governance: A Challenge for Global Health Diplomacy

The Role of Nodal Governance

The *interactive processes for GHG* have created new mechanisms for coordination in this field. Multiple forms of transnational links enable state and non-state actors to *coordinate* all kinds of activities: research, production, marketing campaigns, political strategies, CSO campaigns, and whatever might be of interest for a transnational group of actors. In very open forms of organization, networking is the logical compliment to a system which "anybody can access, use, modify and improve" (Fidler 2007, p. 9). In these networking processes important actors, institutions, media or venues emerge as nodes for information exchange and coordination in relation to specific goals like improving access to medicines, improving support systems for Primary Health Care, etc., to link various types of actors and different fields of activity. This creates forms of coordination, cooperation and networked power which have been characterized by the concept of *nodal governance* (Hein et al. 2009). Informal and formal networking in Geneva and at other regular global health events plays an important role in creating flexible links between global health actors. The concept of **interfaces** between different networks can be used to analyze the "power map" of a governance system and the key characteristics of effective

governance nodes. *The interactions taking place may reshape the goals, perceptions, interests, and relationships of the various actors* (Long 1989, pp. 1–2).

Nodal governance operates in a landscape of mixed social interactions and of conflicting or merging cultural and political habits and behaviours. Nodal governance characterizes many issue-oriented programmes like the *Campaign for Access to Essential Medicines,* where MSF/Geneva acts as the central node linking the activities of many NGOs, the *Peoples' Health Movement* as a large network of grassroots organizations or *Knowledge Ecology International* (*kei online*) as a communication platform in the Internet, providing an information exchange on the impact of intellectual property rights on medical research and access to medicines.

The period of the WHA every May in Geneva has become one of the central nodes for GHG, quite independent from what is being discussed in the formal agenda of the assembly. ***Polylateral diplomacy*** (Wiseman 1999, note 10) is conducted: formal and informal meetings take place, agreements are reached, deals are struck, NGOs exert influence, the private sector lobbies, receptions are organized—in short key global health players participate in the Assembly in this period, even if they are not members of the WHA. On the other hand, the WHA, itself provides a decision-making process at the level of a legitimate international body, allowing nations, which are not powerfully represented in nodal governance processes, to express themselves and participate in legitimate decision making. Linking these levels of nodal governance—providing both the political space for informal negotiation and formal-legal decision-making and managing their interface—is a central task for achieving successful overall coordination in GHG (Kickbusch et al. 2010).

Adapting WHO to GHG Through Institutional Reforms

The WHO was created in 1948 to "act as the directing and co-ordinating authority on international health work" (Constitution of the WHO, Art. 2a). WHO was entrusted with the task of "establishing and maintaining effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate" (Constitution of the WHO, Art. 2b) (see Chap. 9 for more details). However, as an **IGOs**, WHO decision-making (aside from technical matters) has mostly been subject to coalition and bloc building processes among nations as well as to periodic attempts to curtail the autonomy of the organization by powerful states—at times coming close to paralysis (Kickbusch et al. 2010).

Gostin (2007) has proposed that the WHO take full advantage of its treaty-making capabilities and establish a *Framework Convention on Global Health* that ties all major stakeholders (states as well as non-state actors) to the aims of building capacity, setting priorities, coordinating activities, and monitoring progress (see also: Global Health Governance 2010). A second proposal, which has recently gained considerable political attention, builds on the importance of the WHA and recommends that a *Committee C of the World Health Assembly* be established that—in addition to member state representatives—would include

the active participation of international agencies, philanthropic organizations, multinational health initiatives, and representatives from major civil society groups, particularly those who legitimately represent the most vulnerable populations (Kickbusch et al. 2010).

The proposed Committee C would debate major health initiatives and provide an opportunity for the primary players involved in health to present their plans and achievements and offer discussion of collective concerns with World Health Assembly's member state representatives. The Committee would then pass resolutions and would be held to rules of procedure and implementation that respects the mutual sovereignty of all parties. As the only legitimate supranational authority on health issues, the WHO is the appropriate vessel for such a central coordination mechanism that would bring all prominent global health actors to the table for harmonized agenda-setting and decision making. Thus, the Committee C proposal can be seen as creating a link or interface between the nodal governance processes in each sphere of action and the legitimate constitutional position of WHO within a system of sovereign nations. This would greatly improve the chances of achieving productive coordination and the harmonization of conflicting strategies by avoiding or mitigating the clash between power blocs and national coalitions with fixed positions.

Conclusion: Global Governance and Nodal Governance

Globalization has increased the need for international and transnational coordination to "govern" the many global forces that can impact on human health. As in all fields of governance, cooperation and coordination are subjects to shifting political power. New actors that can mobilize discursive political power and bring in new financial and human resources offer the prospect of wider public engagement with and concern for global health, more flexible solutions and faster resolution of issues. This may be seen as a challenge to the power of established actors, but it also offers them the chance to enhance GHG if they can take advantage of these new opportunities (Kickbusch 2009, pp. 320–321).

Many new actors have entered the policy field of global health, bringing additional resources and facilitating the resolution of conflicts by encouraging more flexible approaches and wider public engagement. Yet, in the absence of a central political authority, there are multiple sets of often conflicting rules and norms. Their collective impact on health is a central issue in the discourse on GHG. Forms of **nodal governance** have great potential to transform the institutional architecture. The WHO, vested with the authority to create binding regulations and treaties among member states, could strengthen its role in GHG by linking formal decision-making procedures with processes of **nodal governance**, drawing the many networks of non-governmental organizations that form around specific issues to engage them in global health diplomacy with all relevant actors and publics to develop a wider **governance for global health**.

Questions

1. Which aspects of globalization lead to a transformation of international health challenges?
2. Which are the new types of actors in GHG?
3. Which are the advantages of a proliferation of actors and initiatives in GHG and how are they related to failures of IGOs to deal with new challenges?
4. What is the meaning of "open-source anarchy" and what are the costs of an unfettered proliferation of actors?
5. What is the role of discursive processes for coordination in GHG?
6. How does the Paris Declaration support coordination in GHG?
7. Why does nodal governance imply a reconfiguration of power in GHG?
8. Do you think the Committee C proposal is a way to solve the coordination problem?

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