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Conclusion: The Transformation of Global Health Governance

Abstract: *This chapter identifies how transformations in global health governance are reflected in the governances of specific health issues such as human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), pandemic influenza, tobacco control and access to medicines. It illustrates the importance of ideas such as security, rights, economics, development and bio-medicine in the formation and legitimisation of interests in global health. The chapter explains the link between global health governance and other areas of global governance. It also underscores the multi-sectoral nature of global health governance and how this is reflected in institutions and actors. Finally it suggests that the way forward in improving global health governance is to link health and other concerns both in the framing of issues and in institutional architecture.*

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What is global health governance, where does it take place and to what extent has it been transformed? This book argues that global health governance (GHG) is not a coherent set of rules and norms that are made in an easily identifiable setting. Rather, it is made of a variety of policies – some complementary, some disjointed or even conflicting – which are made in multiple sites and at multiple levels of global governance. GHG is part of a wider system of global governance and shaped by policies and institutions in areas like development, security and trade. At the same time, GHG consists of the governance of a variety of specific global health issues, such as HIV/AIDS, pandemic preparedness, tobacco control and access to medicines.

The book set out to interrogate the relationship between these different sites and levels of global health governance. How are macro-level narratives about global governance and global health governance reflected at the mezzo-level, in the ideas and institutions governing specific health issues, such as HIV/AIDS, pandemic preparedness, tobacco control and access to medicines? How is GHG influenced by trends and changes in other areas of global governance, such as international development, security and trade? And to what extent do the governance structures of specific health issues show distinct characteristics and dynamics? In Chapter 1 we highlighted that the narrative of global governance is characterised by a sense of deep transformation that international relations have experienced in the past three decades or so. In particular, we focussed on globalisation as the driver of GHG, the emergence of different framings and the political contestations that this helped to produce, and the proliferation of actors – including private actors – in GHG. This final chapter uses the same template to structure our conclusions.

Globalisation and GHG

There is a clear sense that the transformation in governance is driven by globalisation, the notion of a compression of time and space through new information and communication technologies, and a growing interdependence of peoples and states through the opening of markets and the ever faster movement of goods and people. In the narratives of global governance, in general, and GHG, in particular, globalisation has increased the number of problems that span national borders and can, therefore, not be solved by national governments alone. Some of

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the most pressing global problems affect the health of people across the globe, such as emerging and re-emerging infectious diseases and the rise of tobacco-related and other non-communicable diseases in countries across the globe.

The case studies examined in the previous chapters explored the link between globalisation and the global governance of specific health issues. All of them find that the emergence of governance responses at the global level was to some extent triggered by the sense that a specific health problem had acquired global dimensions, either with regard to the underlying causes and determinants of the problem and/or with regard to its effects and implications. Importantly, the constructivist approach adopted in this book, highlights that the recognition of a specific health issue as 'global' resulted from the interplay of material conditions with a process of social construction, during which those conditions were interpreted as constituting a global health problem.

One material condition that contributed to the recognition of a health issue in several case studies is an epidemiological situation that reaches crisis level in several countries. Only four years after HIV had first been clinically observed in 1981, it was detected in every region of the world. In the early to mid-1990s, it became widely known that HIV/AIDS had become a spiraling pandemic in many countries of sub-Saharan Africa. This development contributed not only to the recognition of HIV/AIDS as a global health threat, but also raised global awareness about insufficient access to medicines in many low to medium-income countries (LMICs). The spiraling HIV/AIDS epidemic in Africa, therefore, contributed not only to the recognition of HIV/AIDS as a global health problem, but also to that of access to medicines. Pandemic influenza has been a menace to humanity for many centuries. After the Spanish flu of 1918, however, it dropped off people's consciousness due to the emergence of effective vaccines and the lower frequency of pandemics in the second half of the 20th century. The outbreaks of H5N1 ('bird flu') and severe acute respiratory syndrome (SARS) around the turn of the millennium were key in bringing pandemic influenza back onto the global political agenda. The occurrence of a severe health problem in several countries is not restricted to infectious diseases, however. The case study on tobacco control shows that the spread of tobacco-related diseases in LMICs contributed greatly to the recognition of tobacco consumption as a global health problem.

This leads to a second material condition which several case studies identified as an important factor in the construction of health issues as

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global: the global expansion of markets. The increase of tobacco-related diseases in LMICs since the 1980s was closely related to the expansion of tobacco companies into these countries. Partly, this was driven by the desire to compensate for declining smoking prevalence in the traditional markets of high-income countries (HICs), which were implementing stricter tobacco control regulations; partly it was driven by the desire to benefit from the rapidly rising economies in emerging markets. Similarly, the issue of access to medicines became widely recognised as a global health problem in the context of the expansion of Western pharmaceutical companies into emerging markets in the 1980s. This move was, however, impeded by the fact that many LMIC governments did not, at the time, provide for the protection of patents on pharmaceutical products. This severely limited the prospects of Western pharmaceutical companies to gain market shares in these countries, because local producers copied new medicines and sold them at lower prices. As a consequence, the strategy of Western pharmaceutical companies to expand into LMICs contained from the beginning a plan to establish a global regime for intellectual property rights (IPR) protection. The first major success was the World Trade Organization (WTO) TRIPS agreement, which established internationally binding minimum standards for IPR protection. Access to medicines had been a health problem in many LMICs for a long time. Yet, it was not considered a global problem because the impediments to access were considered to be largely local, including poverty, poor health systems and poor infrastructure. For the recognition of access to medicines as a global health issue, the TRIPS agreement was a crucial factor because its internationally binding character represented a truly global obstacle to access to medicines.

The case studies show that material conditions were important for the conception of a specific health issue as global. Yet, the case studies also indicate that material conditions were not sufficient for the notion of a global problem to arise. One indication for this is that, in most cases, there was a temporal disconnect between the existence of certain material conditions and the recognition of a global health issue. For instance, evidence about the spread of tobacco-related diseases existed for more than a decade before the emergence of the global tobacco control movement. And Trade Related Aspects of Intellectual Property Rights (TRIPS) had been negotiated before it was seen as relevant for global health. Moreover, the case studies on HIV/AIDS and pandemic influenza highlight that the diseases/outbreaks which became known

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as the quintessential global health threats were perhaps not the most threatening. For instance, the HIV virus is much more difficult to transmit than other viruses: it cannot be contracted through casual social contact and does therefore not fit into the horror scenarios of a rapidly spreading pathogen that infects millions in a matter of days. Similarly, while individually tragic the impact of the H5N1 ('bird flu') avian influenza outbreak in 1997 was miniscule compared to the Spanish flu but it reintroduced pandemic influenza onto the global political agenda after several decades of neglect.

The role of social construction in the emergence of 'global' health issues is underscored also by our observations that, in most case studies, a group of actors can be identified that interpreted a health issue as global and promoted such an understanding. With regard to HIV/AIDS, the US Christian right called on global humanitarian responsibilities to help people in low-income countries fight HIV/AIDS; the international development community defined HIV/AIDS a key obstacle to global development; and security policy circles interpreted HIV/AIDS as a potential threat to international security. The case study on tobacco control highlights the role of World Health Organization (WHO), its Director-General Gro Harlem Brundtland, and the staff of the WHO Tobacco Free Initiative (TFI) in defining tobacco use as a global health problem. In fact, their construction of tobacco as global health threat made use of language reminiscent of infectious disease outbreaks such as 'tobacco pandemic' to underscore their interpretation of the problem. The case study on global IPR regulation and access to medicines highlights the role of NGOs and some LMIC governments in constructing the global IPR regime as a global health problem.

A third point illustrating the importance of social construction in the emergence of 'global' health problems is that they have often been linked to other issues on the global political agenda. The case studies indicate that the recognition of a health issue as global was facilitated when a connection could be established to other problems that had already been recognised as requiring global attention. For instance, as mentioned earlier, the construction of HIV/AIDS as a global problem was promoted by the international development community. International development had acquired a high priority on the international political agenda since the 1970s, and seen renewed attention after the end of the Cold War. The argument that ill-health in general, and HIV/AIDS, in particular, constituted an obstacle to development was institutionalised in the

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World Development Report 1993: Investing in Health, the establishment of the Commission on Macroeconomics and Health, and the incorporation of HIV/AIDS in the Millennium Development Goals (MDGs). This in turn greatly contributed to establishing HIV/AIDS as a global problem. The acceptance of ill-health as an obstacle to development was a crucial factor also in the successful construction of (the lack of) access to medicines as a global health issue, as it was seen as impeding public health and, hence, development.

Another already existing issue of global concern that has been linked to health problems is international security, as the case studies on HIV/AIDS and pandemic influenza highlight. In the context of the post-Cold War, the international security agenda was being redefined, and the potentially destabilising effects of pandemics on entire states were discussed as a potential new threat to international security. Such arguments became particularly prominent in the late 1990s and early 2000s, and led to the UN Security Council Resolution 1308 declaring HIV/AIDS a 'threat to international peace and security' (UN, 2000b). Similarly, the case study on pandemic influenza illustrates that the 1997 outbreak of H5N1 avian influenza caused particular alarm because not only health professionals but also security experts had been warning of the 'threat' of emerging and re-emerging infectious diseases in the previous years.

The constructivist approach of this book emphasises that the social world does not exist independent of interpretations and that those interpretations also shape that world. On the basis of this approach, the case studies highlight that the recognition of health issues as global was not a quasi-automatic response to globalisation; rather, the emergence of new material conditions was interpreted by specific social groups as constituting a global health problem, and this interpretation had particular resonance when it could be linked to already existing perceptions of other global problems.

Political contestation and cooperation in GHG

The second transformation in GHG identified earlier is the shift from a largely technical field to an area characterised by political contestation and cooperation. The constructivist approach taken in this book highlights that the dynamics of political contestation and collaboration are shaped in important ways at the ideational level. In particular, the case studies show how frames have influenced and legitimised interests,

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and affected power relations. Clashes between different actors about the purpose and design of GHG are driven not merely by opposing material interests; rather, the case studies show that material interests are often intertwined with specific ideational framings regarding the nature of the health problem and, hence, the appropriateness of specific governance responses. Those frames may represent genuinely different worldviews that result in different interpretations of the problem and, hence, the appropriate solution. Yet, frames may also be used in a strategic manner to couch material interests in a wider ideational and normative picture.

How important the ideational level is to legitimise particular interests is evident in the tobacco case study. The opposition of tobacco companies to the increase of tobacco control is based on their desire to protect revenues and profits. Yet, the arguments tobacco companies have presented in the debate do not stress this private interest but focus on alleged interests of the public. Aligning private interests with public interests in political debates is a well-known strategy to increase legitimisation and to mobilise support from other social groups. The companies' arguments that the industry created employment and tax revenues for governments, and fostered foreign direct investment in LMICs appealed to a critical constituency: finance ministries. This constituency is particularly important in governments' decision-making about new policies, including health policies and international treaties, because finance ministries assess their implications for government budgets. In addition, the companies argue that tobacco control interferes with individual liberty, an argument appealing in particular to conservative, libertarian groups in favour of a minimal role for government in society. Finally, tobacco companies speak to popular fears about crime and terrorism by arguing that price increases for cigarettes, a key component of tobacco control, contributed to illicit cigarette trade, which, in turn, benefited organised criminal and terrorist groups. The use of framing has been important also for tobacco control advocates. It appears that improved health has not been a strong enough argument to promote their cause. In particular, the WHO engaged with the industry's framing that tobacco companies are important for economic development in order to win over finance ministries. In this context, the collaboration between the WHO and the World Bank was crucial as it mobilised the World Bank's reputation for expertise in economics for the goal of tobacco control.

Similar dynamics can be observed in the case study on access to medicines. First, pharmaceutical companies (and other industries)

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framed their interest in stronger international IPR protection as important for their home countries' exports and, hence, trade balance. This frame successfully appealed to the interests of ministries of finance and commerce in the United States and several European countries, and secured their governments' support in pushing for an international treaty on IPR, which led to the TRIPS agreement (Sell, 2003). Our case study shows that this framing has been contested by those who see the global IPR regime as an obstacle to global health and international development. Moreover, it shows that the contestation at the ideational level has become institutionalised at the organisational level, juxtaposing international trade organisations, notably WTO, with international development organisations, such as United Nations Development Programme (UNDP) and United Nations Conference on Trade and Development (UNCTAD). Moreover, the frame contestation is also reflected in the positions taken by different government departments at the national level, notably between ministries of commerce and trade, on the one hand, and ministries of health and international development, on the other.

Another frame contestation that has shaped the global politics of access to medicines emerged between the frame that considers global IPR protection as necessary for the development of *new* medicines and the frame that sees global IPR protection as an obstacle for the accessibility of *existing* medicines. The former has been promoted particularly by pharmaceutical companies developing new drugs, which are based primarily in the United States and Western Europe, and their governments; the latter is used by governments from LMICs and nongovernmental organisation's (NGO's) working on humanitarian assistance and international development. This frame contestation, too, has become institutionalised at the organisational level. Some NGOs and LMIC governments focus on changing the global IPR regime. Global health initiatives working on the development of new medicines tend to work within the existing global IPR regime and focus on voluntary licensing of IP rights.

Conflict and contestation between frames is less of a dominant feature in the case studies on HIV/AIDS and pandemic influenza. Although our previous work showed how different frames (especially rights and security) might provide points of contestation in the case of HIV/AIDS (Rushton, 2012), both HIV/AIDS and pandemic influenza also demonstrate that the existence of different frames does not necessarily lead to conflict between them. Rather, key frames in operation in the global

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politics of HIV/AIDS and pandemic influenza have at times even been complementary. They have given different and complementary reasons for the issues be considered global problems, and why it is important to invest in the fight against them. The dominant framing of pandemic influenza in terms of Evidence-Based Medicine (EBM) has been complemented since the late 1990s by a security frame. Rather than challenging the EBM framing, the security frame has supported and reinforced it, and served to highlight the importance of access to vaccines and antiretroviral medicines. Similarly, in the case study on HIV/AIDS we observe that two of the most influential frames, international development and security, have complemented and reinforced one another in the definition of the disease as a global priority. The case study shows how the two frames appealed to and mobilised different audiences, and helped to create an ideational basis on which to legitimise cooperation.

The constructivist approach taken in this book also highlights how frames shape the dynamics of political contestation and cooperation by shaping the power relations between actors, and in particular that a successful framing confers ideational power. The importance of frames for power is particularly evident in the cases on IPR/access to medicines and tobacco control. In both cases, multinational companies with significant material power resources ended up having to make concessions to health advocates with considerably less material power. The case studies suggest that the health advocates were able to offset their material disadvantage by using frames to mobilise support from and foster alliances with other groups.

The proliferation of actors in GHG

A second transformative change that we highlight is the proliferation of actors and, partly as a consequence, the shift from public to private authority. Some of these new organisations have been designed to facilitate cooperation between states to address global problems. In the area of health, examples include United Nations Joint Programme on HIV/AIDS (UNAIDS) and UNITAID, which were created to foster cooperation on the fight against HIV/AIDS, malaria and tuberculosis. Other new actors are entirely new, or new to global health, especially from the private (for-profit and not-for-profit) sectors, which became involved in GHG. They include a wide variety of groups, such as commercial companies,

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advocacy groups, philanthropic foundations, not-for-profit initiatives providing health-related services, and public-private partnerships. The term 'global health initiatives' is used for a wide range of groups engaged in a variety of health issues and fulfilling different functions. They are run as not-for-profit entities and understood as private organisations, even though they usually depend to a significant degree on government funding. Often, global health initiatives combine advocacy for a specific health issue with the delivery of services, such as the development of new medicines and vaccines, their procurement or the creation of new funding mechanisms. Some of these initiatives, especially in the field of pharmaceutical development, operate like virtual (not-for-profit) companies. The shift from public to private authority is associated particularly with the rise of philanthropic foundations and private and public–private global health initiatives. Some philanthropic foundations, notably the Bill and Melinda Gates Foundation, have acquired political authority through the sheer volume of funding they control, which helps them shape the global health policy agenda and the development of global health expertise.

All case studies examined in this book observe a proliferation of actors. Yet, they underscore the need to qualify this narrative because the trend has unfolded much more strongly in some areas of GHG than in others. The case studies also highlight the need to qualify the narrative of the shift from public to private authority: first, the case studies find that states are still important – sometimes the most important – actors in global governance, and, second, the roles and functions of private actors vary greatly. At the horizontal level, new organisations for inter-state cooperation have emerged in all case studies analysed in this book. Among the most prominent in the global governance of HIV/AIDS are the G8, which had a record in addressing health prior to HIV/AIDS but have engaged with HIV/AIDS more than with any other health issue. Other international organisations that came to work on HIV/AIDS include UNDP, United Nations Children's Fund (UNICEF) and the World Bank. A crucial development was the establishment of UNAIDS in 1996 as a 'coordinating body' of the UN on HIV/AIDS.

Many international organisations that moved into the global governance of HIV/AIDS also started to work on the problem of access to medicines, as it had become closely associated with the HIV/AIDS pandemic. In addition, international organisations involved in global trade governance became involved in the global governance of access to

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medicines, notably WTO and various bilateral and regional free trade and investment treaties. They became involved in the global governance of access to medicines because global IPR governance falls largely under the remit of global trade governance. When the global IPR regime was identified as constituting a global health problem, global trade governance organisations found themselves at the centre of the debate.

The case studies on pandemic influenza and tobacco control have found less involvement of new actors, and emphasise the key role played by the WHO. WHO's Global Influenza Surveillance and Response Network (GISRN) and the TFI respectively have played the key role in establishing and running the global governance of these two issue areas. Some intergovernmental organisations not traditionally working on influenza preparedness have, however, become involved recently, such as the Food and Agriculture Organization (FAO), the World Bank and the World Organization for Animal Health (OIE). In addition, the office of the United Nations System Influenza Coordinator (UNSIC) was established to help coordinate the work of various UN agencies. The case study on tobacco control notes the least involvement of new public actors in global tobacco control. In fact, the WHO was itself a new actor and has taken the lead on governance of this issue since the late 1990s. It did enter into an important collaboration with another international organisation, however, namely with the World Bank to publish the report *Curbing the Epidemic: Governments and the Economics of Tobacco Control* (1999).

With regard to the involvement of private actors, our case studies show an even greater degree of variation than with regard to the involvement of new public actors. Starting with a commonality, however, we find that NGOs played an important role in the process of establishing health issues as global and bringing about global governance responses in all case studies except pandemic influenza. This is most evident in the case studies on HIV/AIDS and access to medicines. Activist groups, often consisting of, or working closely with, patient groups, played a crucial role in raising awareness about HIV/AIDS and its global dimensions. Similarly, NGOs were the first to take up the issue of the global IPR regime constituting a potential threat to access to medicines. In both cases, NGOs were also key in bringing about specific governance responses, such as including HIV/AIDS in the MDGs and bringing about the WTO Doha Declaration on the TRIPS Agreement and Public Health.

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The case study on tobacco control, too, highlights the role of NGOs in bringing about a specific governance response, the Framework Convention on Tobacco Control (FCTC). Of particular importance was the NGO 'Framework Convention Alliance', which lobbied governments to support and implement the FCTC. An interesting aspect highlighted by this case study is the important role that the WHO played in mobilising NGO engagement. Global tobacco control efforts, including the FCTC, had been initiated largely from within the WHO. Yet, the WHO engaged with NGOs from an early point on, for instance through consultations, public hearings and by offering accreditation as observers. Engagement with NGOs was considered important, in particular, to balance lobbying from the tobacco industry, and legitimise collective action on tobacco control. The development of a global governance response for tobacco control did remain largely in the hands of WHO, but the engagement of NGOs was actively promoted and, to some extent, even formalised through the possibility of obtaining observer status.

With regard to the *degree* of formal involvement of NGOs in GHG, however, we observe a difference between the case study on tobacco control, on the one hand, and those on HIV/AIDS and access to medicines, on the other. In the latter two, some NGOs have become involved in GHG to the extent that they have taken on governance functions themselves. They have become partners in numerous global health initiatives, such as the Global Fund, GAVI and the Patent Pool, and have been given formal representation on governing boards. In these cases, NGOs have moved from the role of outside lobbyists to insiders that are directly and formally taking on the role of global governors.

Similar to NGOs, commercial companies shape GHG as both outside lobbyists and inside partners in global health initiatives. Whether they lobby for or against these initiatives depends on the type of governance response in question and on their business model. The role of commercial companies is least ambiguous in the case of tobacco control. The very product of the tobacco industry is the cause of the health problem identified. Any governance arrangements that are aimed at tightening tobacco control, therefore, meet with opposition from the tobacco industry. The clear position of the tobacco industry in this issue area of GHG explains why WHO took the unusual stance of limiting the engagement of tobacco companies in FCTC negotiations. Like other private groups, tobacco companies were permitted to submit evidence to the public hearings, but they were not given the opportunity to attend formal negotia-

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tions as observers. The role of pharmaceutical companies in HIV/AIDS, access to medicines and pandemic influenza is less straightforward. The key difference is that pharmaceutical companies produce a product that is central to *addressing* health problems – rather than being their cause. For this reason, governments and NGOs alike have usually been keen to establish cooperative relations with pharmaceutical companies. Problems have emerged where there is a conflict between the social need for certain medicines and the existing business model to develop them.

This issue is highlighted in particular in the case study on IPR and access to medicines, but it runs across the cases on HIV/AIDS and pandemic influenza as well. The existing model for the development of new medicines and vaccines is based on the assumption that this can be done most effectively and efficiently as a commercial (in other words, for-profit) enterprise. The currently dominant model to guarantee profitability is the granting of temporary market monopolies. Companies that produce a new medicine or vaccine are granted the exclusive right to market the product for a specific period of time (through patents and other forms of IPR). Temporary market exclusivity guarantees the profitability of pharmaceutical development because, in the absence of competition, the innovator company is free to set the price for the new product – and to do that at a level that recoups investment costs and also reaps profits high enough to satisfy shareholders. From a governance perspective, this model of pharmaceutical development creates problems at two levels: firstly, where there is social demand for medicines that is not matched by market demand (that is, when patients are too poor to afford the medicines they require from a medical perspective); secondly, where opportunity costs prevent pharmaceutical companies from investing in the development of certain medicines that are needed to address public health problems (that is, when the returns on investment are higher for the development of medicines for other diseases).

The cleavage between pharmaceutical companies' importance as a source of technologies required for improving health outcomes and their current business model impeding access to these very technologies has shaped their involvement in GHG. It has mobilised concerted lobbying attempts on the part of pharmaceutical companies to increase global IPR protection and enforcement, which has antagonised many public health advocates. At the same time, pharmaceutical companies have become involved in global health initiatives that work to make medicines and

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vaccines more accessible, and develop new products for hitherto neglected diseases, either through product development partnerships or new funding mechanisms.

Public–private, or entirely private, global health initiatives have acquired considerable political authority in some areas of GHG, such as HIV/AIDS and access to medicines. Their authority is based on their demonstrating new ways of addressing global health problems, such as not-for-profit pharmaceutical development and innovative funding mechanisms. It is based also on the sometimes considerable expertise that global health initiatives command, and not least on the financial backing they receive from foundations, notably the Bill and Melinda Gates Foundation. The case studies demonstrate, however, that the role and authority of global health initiatives is considerably greater in some areas of GHG, such as HIV/AIDS and access to medicines, than in others, such as pandemic influenza and tobacco control. This indicates that the narrative about the proliferation of actors and the shift from public to private authority in global governance has to be qualified. Moreover, even the case studies that observe an increasing role and authority of private actors maintain that state actors continue to play an important, if not the most important, role. In this context, the case studies also highlight considerable variation in the role and importance of the WHO. The Organisation has played a leadership role in developing and implementing global governance responses to pandemic influenza and the rise of tobacco-related diseases. Its GISRN forwards national surveillance data and virus samples to WHO reference laboratories, which identify the dominant strains and pass relevant information on to pharmaceutical manufacturers to develop influenza vaccines. The GISRN was also instrumental in strengthening the role of global-level governance responses in the 1990s again, after pandemic preparedness had dropped off the international political agenda for several decades. In the case of tobacco control, WHO, under the leadership of Gro Harlem Brundtland, was key in establishing tobacco-related diseases as a global health issue. The WHO Director-General and the newly established TFI exercised strong leadership in initiating and shaping the negotiations that led to the first multi-lateral treaty created in WHO, the FCTC.

In the global governance of HIV/AIDS, the WHO started off in a central role. As the UN organisation mandated to promote international cooperation on public health, the WHO was one of the first international organisations to respond to the new disease, and established the

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Control Programme on HIV/AIDS. Reflecting the growing awareness of the scale of the disease and its increasingly global reach, the programme was expanded and renamed as the Global Programme on HIV/AIDS in January 1988. This was intended to reflect the need for the WHO to have a permanent and sustainable work programme focused on HIV/AIDS. By the mid-1990s, however, the leadership role of the WHO on HIV/AIDS was already put into question with the argument that the disease was a multi-sectoral problem and, hence, required a multi-sectoral governance response. This interpretation became institutionalised with the creation of UNAIDS in 1996.

With regard to the debate on IPR-related aspects of access to medicines, it took the WHO a few years to establish itself as an important forum of global political debate on the issue. When the debate emerged, IPR protection was still considered exclusively an issue of international trade governance, and the global IPR regime was institutionalised in an international trade treaty, TRIPS, which was administered by WTO. As a consequence, the debate on IPR and access to medicines initially focussed on WTO and on potential changes to the TRIPS agreement (which led to the WTO Doha Declaration on TRIPS and Public Hhealth in 2001). Although the WHO had addressed IPR-related aspects of access to medicines in 1998 in its Revised Drug Strategy, it took five more years for the Organisation to take a leadership role in the global debate. It was only in 2003 that WHO established the Commission on Intellectual Property Rights, Innovation and Public Health, followed by the Global Strategy and Plan of Action in 2008, and the Consultative Expert Working Group on Research and Development in 2010. These initiatives proposed alternative financing mechanisms for developing neglected disease drugs, and have contributed to consolidating expertise and moving the debate forward. Yet, they have largely left out the problem of how to improve access to *existing* medicines. The WHO has contributed little to addressing the continuing trend of expanding IPR protection through the growing network of bilateral and regional free trade and investment treaties, and largely left the debate on how to address problems of access to existing medicines to organisations operating in the field of global trade governance.

How can we explain the divergent roles that the WHO has played in different areas of GHG? Our case studies suggest that a combination of three factors may help answer this question: leadership (or the lack thereof); institutional path dependence; and existing power relations.

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The case study on tobacco control emphasises the leadership of Gro Harlem Brundtland when she took over as Director-General and decided to focus on two global health problems in particular during her time in office: tobacco control and malaria. It also highlights the leadership of the staff of the TFI unit, including Derek Yach. Pandemic influenza is the other case study identifying a strong leadership role of the WHO, but this case indicates a different reason for the WHO's pronounced role: institutional path dependence. The WHO took on the issue of pandemic preparedness shortly after its inception with the creation of GISN/GISRN in 1952, which became an authoritative source of information on the spread and emergence of new strains of the disease. The WHO lost its dominant role when pandemic preparedness became an issue of national policy in the 1970s and 1980s, but it was the global institution of choice to take up leadership again in the late 1990s with the outbreak of H5N1. The WHO's established position in the global governance of pandemic preparedness combined with the availability and proven efficacy of an intervention technology, vaccines, may explain why the WHO leadership role in this area has so far not been questioned. Another reason may be that pandemic influenza has so far not been linked strongly to other global problems and, therefore, other actors and institutions have not yet laid claim on the leadership role.

The latter considerations emerge from the analysis of the other two case studies, IPR/access to medicines and HIV/AIDS. Similar to pandemic influenza, the case study on access to medicines illustrates the importance of institutional path dependency: with regard to the institutional embeddedness of IPR in the WTO, in particular, and in global trade governance, in general. The link between IPR and trade had been institutionalised during the Uruguay Round negotiations of the General Agreement on Tariffs and Trade (GATT) in the 1980s before IPR was linked to health. Some kind of institutional 'stickiness' may, therefore, partly explain why the WHO has found it difficult to take over leadership from WTO with regard to IPR-related aspects of access to medicines. Yet, a closer look at the case reveals that the institutionalised link between IPR and trade has been supported by an alliance of powerful interests: the governments of the United States and the European Union, and IPR-sensitive industries such as the pharmaceutical, audio and recording and the software industries. The link between IPR and trade aligns the interests of these industries in temporary monopolies for their new products with the interests of their governments in protecting key

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export industries, which help counterbalance the growth of imports from emerging markets and, hence, help protect the countries' trade balance. Several studies have demonstrated that the creation of a link between IPR and trade and its institutionalisation in national trade bodies and in WTO has been the result of a concerted political strategy (Sell, 2003; Ostry, 1990). The creators and beneficiaries of the link between IPR and trade are unlikely to accept that it is weakened by sharing governance competence for IPR with the WHO.

In the case of HIV/AIDS, the WHO lost its initial position as the lead agency in the global response in part because of the increasing belief that the pandemic, which cuts across all sectors of society, required a multi-sectoral response, and in part because other UN agencies and donor governments were dissatisfied with the effectiveness of the WHO's efforts to coordinate the global response and perceived the WHO's HIV/AIDS programme under Director-General Nakajima to be too narrowly focussed on HIV/AIDS as a health issue (Lisk, 2010, pp. 23–4). UNAIDS was created to address this problem, and although the WHO has maintained an important role as a UNAIDS co-sponsor (especially in technical areas such as the development of treatment guidelines) it no longer has lead status – even less so after the creation of the Global Fund, the most significant multi-lateral funding mechanism for AIDS, which bypassed the UN system entirely.

Conclusion: social construction and multi-sectoral dynamics in the transformation of GHG

That the governance of health globally has been transformed is, at its crudest level, suggested by the emergence and common usage of the term 'global health governance'. This book, however, identified this transformation as consisting of three elements, which structured both the case studies and this final chapter, and explored how these macro-level transformations were reflected in the governances of specific health issues. Each of the case studies demonstrates the presence of each of the transformations, though to differing degrees and in different ways. That there is a high level of commonality should not obscure these differences.

This book also illustrates the importance of ideas and framing for the formation and legitimisation of interests and for the balance of

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power between groups. Furthermore, it shows that the process of social construction is an important link between GHG and other areas of global governance. The case study on access to medicines highlights how events in global trade governance have been interpreted at specific points in time as affecting global health. Hence, ideas and institutions governing global trade governance, such as WTO and its agreement on TRIPS, and the various bilateral and regional free trade and investment treaties, have shaped the development of GHG. Similarly, the case studies on HIV/AIDS and pandemic influenza highlight how developments in international security, including the redefinition of the international security agenda after the end of the Cold War and new security concerns following the 2001 terrorist attacks and anthrax letters, have given rise to the notion of health security. This in turn, has shaped policy agendas and governance responses at the national and global levels in these two issue areas. Yet, the book also demonstrates that the link between GHG and other areas of global governance is not a one-way street. Events in global health have been noted in other areas of global governance, and interpreted with regard to their meaning for issues of international development, trade and security. The spiralling HIV/AIDS pandemic in many sub-Saharan African countries has contributed significantly to the redefinition of the role of health in international development. It has also reinvigorated global debates on how trade policies affect social development, and fed into emerging ideas of human security (for example Kaldor, 2007), which widen the notion of security to include not only states but also individual livelihoods.

The case studies therefore underscore the multi-sectoral nature of GHG, which is influenced by and, in turn, shapes developments in other areas of global governance. Moreover the case studies show that the multi-sectoral dynamics of global governance are at play not only with regard to the relations between global health and other areas of global governance, but also with regard to relations between different issue areas within GHG. This is evident most clearly in the cases of HIV/AIDS and access to medicines. The HIV/AIDS pandemic had triggered the engagement of numerous organisations from high-income countries and from the international community. Many of these organisations worked directly with patients in LMICs and, thereby, experienced first-hand the problems of access to medicines. This contributed greatly to raising global political attention for the issue, and, combined with the

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catastrophic dimension of the pandemic, helped bring the issue of access to medicines on the agenda of trade and security communities.

The multi-sectoral character of GHG has become manifest also in the institutional structures of global governance. As mentioned earlier, UNAIDS was founded in 1996 as a UN agency intended to reflect the multi-sectoral nature of HIV/AIDS; and UNSIC was created to coordinate influenza-related activities of various UN agencies. The institutionalisation of the multi-sectoral nature of global health is evident also in the case of access to medicines, where both the WTO Doha Declaration on the TRIPS Agreement and Public Health and the WHO Department of Public Health, Innovation and Intellectual Property reflect the intertwined nature of trade and access to medicines.

The emergence of global governance institutions that reflect the multi-sectoral character of global health points to a promising avenue in the quest for more effective GHG. As mentioned earlier, framings of global health problems that emphasised the link to other global issues have not only contributed to greater contestation in GHG but also created room for cooperation by appealing to and mobilising different audiences around a common cause. The emergence of global governance organisations that reflect the multi-sectoral character of global health institutionalise both the ideational link and the coalition of interests that have formed around it. GHG, from this vantage point, resembles a kaleidoscope of continually changing patterns where ideas play a crucial role in fuelling conflicts between health and other global issues on some occasions, but can also create room for cooperation on other occasions.

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