Introduction

After World War II, international public policies understood as “international actions that serve broadly agreed public ends” (Severino and Ray 2009) largely coincided with North–South relations and the international development cooperation system. With the acceleration of the globalization process, the rapidly changing geo-political scenario, and the ever-expanding range of transnational challenges confronting the international community, the situation changed substantially over the last two decades, dramatically increasing the scale and complexity of public policies. These changes can be described as a triple revolution of objectives, players and instruments. Indeed, development goals and targets are being reset “post-2015” to respond to the new challenges. Public policies are increasingly subject to transnational actors and new power balances that override the traditional domain of international relations and policy-making, and may undermine the mandate of existing multilateral institutions, while a “bustling creativity of development finance is precipitating a change of era” (Severino and Ray 2009). Indeed, the global health domain offers a good example of such changes and challenges.

The interdependency among national health systems and the interconnectedness between health and the multifaceted aspects of development have dramatically increased. Thus, a wide range of health determinants is of worldwide relevance. In the global health system alone, medical technologies are developed and traded globally by transnational companies, medical knowledge is shared by a global community of professionals and patients, and, finally, the health care workforce and, increasingly, cross-border services have increased the fluidity of national borders.

Since the late 1990s, the role of health in global development policies became more relevant; three out of the eight Millennium Development Goals (MDGs) set forth in the year 2000 by the United Nations Millennium Declaration, are related to health targets (MDG 4: Reduce child mortality, MDG 5: Improve maternal health, MDG 6: Combat HIV/AIDS, Malaria and other diseases). This shift in attention to health also resulted in an unprecedented growth at a global level of financial resources destined for the development of the health sector (IHME 2014).

The mushrooming of new private actors and a vast array of global alliances and public–private partnerships, together with the growing role of emerging countries, brought about
considerable changes in global health governance, posing new challenges to international institutions with the mandate of international coordination, particularly to the World Health Organization (WHO).

“Health policy is about process and power”; thus it becomes extremely important to understand “who influences” whom in policy-making (Walt 1994). A number of factors exogenous to national governments and political systems influence national health policy formulation and implementation. Indeed, in an interdependent world, “governments are increasingly affected by international policy procedures”; thus, identifying who is and how they are driving decision-making at global level is of vital importance (Walt 1994). Over the years, a multitude of different actors, each accountable to different constituencies and with different agendas, influenced the global health agenda beyond the programme of the World Health Assembly (WHA).

Meanwhile, many policies directly or indirectly influencing health and health systems were increasingly defined in other international and global arenas. The current global changes (and challenges) include the cross-border displacement of populations, goods and services, monetary resources, ideas and information as well as global environmental degradation and climate change. All of these dimensions have a strong influence on the living and health conditions of people globally. Thus, the need to go beyond global health governance, to embrace global governance for health – i.e. to privilege health as a priority goal in decision-making processes outside the traditional domain of health authorities – is increasingly being recognized (Ottersen et al. 2014).

In the following sections, a brief historical review of the evolution of global health policies highlights some of the “processes and powers” that have been shaping global health governance. Subsequently, a brief analysis of main actors will attempt to map influences and identify main global governance issues at stake.

The evolution of global health policies

In 1946, the member states of the newly formed United Nations gathered in New York to draft and sign the constitution for the WHO, which entered into force in 1948. “The attainment by all peoples of the highest possible level of health” was the objective of the new organization, while its mandate was to “act as the directing and co-ordinating authority on international health work”. Health was recognized as a fundamental human right and defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”, implicitly recognizing that the promotion of good health is not the sole responsibility of health authorities, but requires a much wider and inter-sectorial approach (WHO 2005).

In 1977, the World Health Assembly, the organization’s representative body, adopted the goal of “Health for all by the year 2000”, and the following year, with the Alma-Ata Declaration, Primary Health Care (PHC) was identified as the best strategy toward that objective. The Alma-Ata Declaration promoted an approach based on equity and community participation, focusing on prevention and appropriate technology, with an integrated inter-sectorial approach to development. The approach would have immediately had substantial societal and structural implications; thus, a number of governments and agencies quickly pushed to reduce the spirit of Alma-Ata to a practical set of technical interventions, giving birth to “selective Primary Health Care”: low-cost interventions, pragmatic and limited in scope (Brown et al. 2006). This reductionist, centralist approach would soon become dominant with the advent and prevalence of neoliberal policies.

Attention was drawn away from health and focused on the control of single diseases. Under the strong influence of international organizations and bilateral agencies, this soon resulted in
the reorganization of health systems into “vertical programs”, prompting a multiplication of costs and a waste of resources, not to mention the complete detachment of these programs from development actions being implemented in other sectors (education, agriculture, industry, social infrastructure, etc.).

In those years, under the inspired leadership of its Director General Hafdan Mahler, WHO openly challenged the commercial practices of transnational pharmaceutical and food industries (Global Health Watch 2005). The International Code of Marketing of Breast–Milk Substitutes – adopted by the 34th World Health Assembly – and the Essential Drugs Program were fiercely opposed by the government of the United States of America, under the influence of powerful food and pharmaceutical lobbies, which claimed those initiatives to interfere with global trade and marketing practices.

As a consequence, the US led the World Health Assembly to freeze WHO’s regular budget and later (1985) withheld their assessed contribution to WHO. The financial challenge that WHO had to face initiated a significant change in the way global health priorities were defined. A crucial shift took place from predominant reliance on the regular budget, drawn from member states’ assessed contributions, to greatly increased dependence on extra-budgetary funding, defined as “voluntary” contributions from member states and external contributors who pledged according to their own priorities for programs with a variable degree of independence from WHO’s institutional decision-making structure. By the beginning of the 1990s extra-budgetary funds represented 54 per cent of WHO’s total budget, and that percentage would progressively grow over the years to nearly 80 per cent in the current decade.

Toward the end of the 1980s, as an integral part of neoliberal macroeconomic structural adjustment programs (SAPs), the World Bank pushed developing countries to adopt a single-recipe Health Sector Reform, encouraging privatization of health services, fostering the introduction of private insurance schemes, and enforcing user fees for health services. Structural adjustment policies imposed on poor countries were among the main determinants in the worsening of people’s living conditions and in the collapse of countries’ health systems. In the 1990s, the World Bank started to directly orient the global debate on health.

During this decade, the international health scene was progressively changing. WHO’s role was further weakened by an increasing number of players in the global health arena. In addition to the World Bank and other UN organizations, regional development banks and funds, multinational pharmaceutical companies, actors from the private and corporate sectors, and a growing number of non-governmental organizations (NGOs) from the non-profit-making sector were all claiming a role in the health sector. Among the new actors appearing on the global health scene in that period was the Bill and Melinda Gates Foundation, which would soon become the single most important non-institutional player on the global field.

In the changing scenario, Global Public–Private Partnerships (GPPPs) emerged as a new approach to improve the delivery of health services for a number of health problems. Many GPPPs were created during the late 1990s to focus on specific diseases.

Claiming a lack of public resources, wherein the reality was instead one of reduced public commitment and of progressive privatization of international aid, the rhetoric of partnership became the dominant topic in the global debate. The creation of joint public–private ventures was presented as a “requirement” to bring health to the centre of poverty reduction and development strategies (WHO 2001). No evidence was provided for that requirement.

The number of health–related GPPPs increased rapidly, soon surpassing 90 in the first years of the new millennium, thus duplicating interventions and further fragmenting global action for health, with heavy consequences in terms of health governance, both at national and global levels (Missoni 2004). Initiated by the Gates Foundation, the Global Alliance on Vaccines and
Immunizations (GAVI), launched in the year 2000, became the reference model for that approach, and inspired the Group of Eight (G8) to launch the Global Fund to fight against HIV/AIDS, Tuberculosis and Malaria (GFATM) the following year. Multilateralism, represented by the United Nations, has been progressively depleted while the G8 has grown in importance under the leadership of a few wealthy countries.

Despite advocating for a systemic approach to health and “Healthy Public Policies” (orienting public policies in other sectors toward health objectives), a concept established in the Ottawa Charter (WHO 1986), in practice, under Gro Harlem Brundtland’s direction, WHO openly supported GPPPs and their “vertical” approach toward specific diseases and health issues. No attention was paid to possible consequences in terms of overall global health governance, fragmentation and WHO’s own organizational policy. Indeed, partnerships and other interactions with the corporate sector also represented an important shift in organizational policy (Deacon et al. 2003).

The influence of private foundations (e.g. Gates) and public–private partnerships (e.g. GFATM, GAVI) continued to grow throughout the decade, undoubtedly representing the most significant trend in the global health scene. Although in some cases they may have facilitated access at a national level to drugs and services for the treatment of specific diseases (Buse and Harmer 2007), the fragmentation produced by the increasing number of “vertical” initiatives in the wider context of development aid, their arguable sustainability, and the waste of resources due to duplication and lack of alignment to national health plans, gave rise to increasing doubts about effectiveness and appropriateness of that approach among very diverse observers (Conway et al. 2007; Garrett 2007; Hsiao and Heller 2007; IDA 2007) and raised new questions about global health governance and the role of WHO (Bartsch 2007; Nishtar 2004).

Despite an increase in participants and an increased interest in the global health arena, the political space for a comprehensive approach to health and a systemic approach was getting progressively narrower.

The systemic approach to health was revamped by the almost contemporaneous publication of the Report of the Commission on Social Determinants of Health (CSDH) and, on the 30th anniversary of the Declaration of Alma-Ata, the WHO’s 2008 Annual Report, which refocused on Primary Health Care. The latter critically assessed the way that health care is organized, financed, and delivered in rich and poor countries around the world, challenged by hospital-centrism, fragmentation deriving from multiplication of programs and projects, and the pervasive commercialization of health care driving health systems away from their intended directions (WHO 2008). The CSDH concluded its Report by redefining the overarching significance of health as possibly the most comprehensive indicator for development (CSDH 2008).

The recognition of the relevance of health determinants (social, economic, political and environmental) and their strong relationship with processes of production and consumption, with societal structure, and with decisions made outside the traditional domain of health authorities, prompted the need for a global governance that would take health goals and the priorities of public health into every arena (e.g. agriculture, commerce, industry, education, environment) in which public policies are developed and negotiated (Frenk and Moon 2013).

In the wider debate also traditional inter-national decision-making and governing mechanisms between and among nation states was challenged, and it was suggested that a wider range of public and private trans-national stakeholders should be involved in a multi-stakeholder, multi-level approach (Kirton and Cooper 2009).

In this changing global scenario, the WHO faced increasing challenges in playing its original leading role derived from its constitutional mandate and proposals were made for new governance frameworks, including a Framework Convention on Global Health which would
redesign current global governance mechanisms into an international binding agreement (Gostin et al. 2013).

The current scenario: players and interests at stake

In a first attempt to define and shape the architecture of Global Health Governance, Dodgson and his collaborators represented it graphically in progressive circles, according to distance from central “leadership and authority” (Dodgson et al. 2002). Although already recognizing the emergence of new actors (i.e. the Gates Foundation), in the central circle they only put WHO, the World Bank and the USA. After just over a decade, the scenario is totally different and rather unstable. A short analysis of main players will allow us to better understand the balance of powers and to re-draw the map (Figure 21.1).

The World Health Organization (WHO)

Due to its mandate, the WHO formally remains the international health authority at the centre of the map. The resolutions of the World Health Assembly are not binding, but are still regarded as a reference for international action, so much so that on more than one occasion when a decision was perceived as contrary to individual interests, single member states and/or external actors acted to derail the decision-making process.

![Global health governance diagram](image)

**Figure 21.1** Global health governance

Source: Dodgson et al. 2002; modified

Note: Arrows show increased centrality of actors. Actors in boxes were not present in the original map.
With the regular budget frozen since the early 1980s, the prevalence in the overall budget of donors’ earmarked voluntary funds remains the most visible obstacle to WHO autonomy. In 2014 extra-budgetary funds represented 76 per cent of total funding. Of these, the highest portion – approximately 18 per cent – came from a single private donor: the Gates Foundation, which ranked second only to the United States of America (which also provides assessed contributions) as a contributor to WHO’s total budget (WHO 2014).

Although facing dynamics for which it was not designed, WHO still has the normative and regulatory instruments, seldom used until today, to affirm and defend the right to health. Experience has shown that forming strong alliances may be key in confronting the most difficult challenges. For example, in the case of the Framework Convention on Tobacco Control (FCTC), allying with wide civil society movements, WHO was able to promote and attain a binding international agreement, despite the harsh opposition of the United States and of the powerful tobacco lobbies (Collin and Lee 2009).

Accused of lack of transparency or ineffectiveness in complex situations (such as the swine flu and the Ebola pandemics), and with a tendency to bow to the will or large economic powers, the Organization underwent a serious credibility crisis (Prah Ruger 2014). However, one should not underestimate the role of the member states themselves, and especially major contributors, in undermining WHO credibility and sustainability, by deviating their financial support toward an entropic plethora of new actors, which in many cases they themselves created and finance as in the case of the GFATM (Lidén 2014).

It was the debate about “The Future of Financing for WHO” presented at the 64th WHA in 2011 that actually introduced a broader reform process. While the results are still uncertain, the reform contained a far-reaching agenda that hoped to reshape the way in which the organization operates, is governed, makes decisions and is financed, and probably its overall role in the global public health arena.

Some consider that politics should be maintained out of WHO and would prefer to see its role reduced to that of a purely technical body, and eventually a provider of technical assistance for new initiatives, alliances and other groupings. However, this would further weaken the highly fragmented global health architecture and its current coordination mechanisms; instead, a healthier political functioning should be pursued (Lee 2009).

In this context a highly sensitive issue is how to give voice to multiple stakeholders, but particularly how to differentiate between very different interests. It may be dangerous to group very different entities such as NGOs advocating for health as a human right, businesses lobbying for their commercial trade-off, and influential Global Philanthropies sometimes pursuing individual objectives and sets of values all under the same umbrella category of “non-state actors” (Richter 2014).

The World Bank

In 2007, the World Bank launched its new Health, Nutrition and Population Strategy re-focusing on long-term, country-driven and country-led support. Based on its comparative advantages, the World Bank proposed itself as the lead global agency for health system strengthening, health financing and economics (Hafner and Schiffman 2013). This raised immediate concern when considering the World Bank’s previous role in pushing structural adjustment programs and health sector reforms, and its continued promotion of pro-private market-oriented policies that underpin many of the current problems in poor countries (McCoy 2007).

In 2009, the World Bank joined the GFATM and the GAVI in the establishment of a “Health Systems Financing Platform”. Again, doubts were raised about the credibility of such
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a platform, and the will of the World Bank (beyond mere rhetoric) to follow principles of aid
effectiveness including ownership and alignment, especially in the absence of formal agreements
for a real collaboration at country level (Brown et al. 2013).

In 2012 the appointment to the Presidency of the World Bank of Jim Kim, a medical doctor,
anthropologist and global health expert, was seen as a sign of change; a potentially unique
opportunity for the World Bank to exercise its authority to assist countries in agenda setting and
generating political will for collective action on health (Prah Ruger 2013). Certainly, the World
Bank remains a major channel of Official Development Aid (ODA) (IHME 2014) and a
fundamental actor in the macroeconomic scenario.

Other UN system entities

Several other organizations and bodies belonging to the UN system directly or indirectly
include health in their mandate and often develop joint programs with WHO. The role of
UNAIDS, born to ensure coordination of HIV/AIDS control activities among UN agencies,
grew with the relevance of the pandemic; however, it was later somewhat dwarfed by the UN
Secretariat and main donors’ choice to establish the GFATM.

The United Nations Fund for Population Activities (UNFPA) is widely involved in
reproductive health initiatives, and UNICEF integrates children and youth health into the
wider context of its mission for the promotion of children’s rights.

Although acting in a different sector, the mandate of a number of the UN’s specialized
agencies is linked to health determinants. This is the case for example of the Food and
Agriculture Organization (FAO), through food policies, or the International Labour
Organization (ILO) which engages in social protection.

World Trade Organization and trade agreements

The health consequences of trade policies and agreements have been too often neglected. Thus,
the World Trade Organization (WTO), with a mission of promoting free trade and tasked with
the management of multilateral trade agreements, also plays a role in determining health policies.
Binding provisions such as the Trade Related Intellectual Property Rights (TRIPS) agreement
or the General Agreement on Trade in Services (GATS) have significant impacts on health
when applied in certain cases. Other agreements make specific reference to international health
standards, for example those of the Codex Alimentarius, jointly developed by WHO/FAO,
which evaluates technical barriers that may interfere with free trade. The Agreement on
Technical Barriers to Trade (TBT) and the Sanitary and Phytosanitary measures (SPS) are also
valid examples of the ways in which trade agreements directly impact health. The rigid
regulation of these international agreements (hard law), may serve an important function in the
free circulation of goods and services, but may simultaneously have catastrophic impacts on
health and access to health services.

In the last decade the multilateral trade system has been challenged by the increasing tendency
of major economic powers to privilege bilateral and regional trade agreements. Lack of
transparency in their negotiations and power asymmetry among stakeholders increase the
chances that public interest and hazards to health are not taken into consideration. The
weakening of legislation is ultimately detrimental to the protection of the environment,
agriculture, the food chain, and, subsequently, citizens and consumers (Cattaneo 2015)
Bilaterals and their groupings

Dodgson and co-authors (2002) did not put any bilateral donor but the USA, at the centre of their “Global Health Governance Map”. Other wealthy OECD countries instead influence global health through their participation in WHO and other multilateral contexts, including the governance of GPPPs. The G8 influence on the global health agenda as a collective body received an important push in 2000 under the Japanese presidency and has since increased considerably in importance with the launch of the GFATM the following year. However, the modification of international geopolitical and economic balances may soon modify that supremacy.

China, already the second world economy is also playing a growing role on the global health stage. Together the BRICS (Brazil, Russia, India, China, South Africa) are progressively engaging in a common global health strategy (Acharya et al. 2014), including in WHO (Gautier et al. 2014). In contrast, 2014 was the first time that the G20 directly addressed a health issue in a separate statement, and this was specifically due to the ravaging Ebola epidemic (Kirton 2014). The rise of new power blocs, such as the BRICS, might eventually change the balance in negotiations. However, it has been argued that these emerging economies do not alter the dominant development paradigm; instead they aim at rapid growth at any cost, regardless of negative socio-environmental and health impacts, thus making them part of the problem instead of the solution (Ferreira et al. 2013). In addition, major differences between BRICS countries and marked inequalities within each of them, represent an additional hardship.

Transnational private actors

Private actors first need to be differentiated between profit and non-profit, and the latter must be further subdivided into the so called Global Philanthropies, such as foundations and a multiplicity of other non-profit distributing associative entities. Direct or indirect influence of transnational companies (TNCs) on decision-making processes that influence global health should not be underestimated. TNCs exercise pressure, and not always in the most transparent ways, to favour the widening of their markets and to limit public regulation as much as possible. Individually, or through their associations, TNCs have progressively extended their influence on the development of health policies at an international level, both by lobbying national governments to support their positions and through direct interaction with the relevant international organizations. Historical examples include the previously mentioned resistance toward the WHO/UNICEF code on baby food, the WHO essential drugs programme, and the FCTC.

TNCs also engage in health and social development as part of their “corporate social responsibility” (CSR) which is increasingly becoming part of business as usual to respond to accountability issues, ensure strategic positioning, influence the socio-political milieu, and promote TNCs’ own commercial interests. Massive donations, largely to United Nations programs or the initiatives of corporate foundations, are usually motivated by marketing purposes rather than the philanthropy and legacy that normally motivate family foundation decisions (Buse and Lee 2005).

Foundations established by wealthy individuals or their families (e.g. the Rockefeller Foundation, Wellcome Trust, Ford Foundation, UN Foundation, Aga Khan Foundation) have often played an important role in financing health activities and influencing policies transnationally, directly or through WHO and other international institutions (Birn 2014).

With the emergence of the Gates Foundation in the late 1990s the volume of financial contribution passed from millions of US dollars to billions. With a capital of about 40 billion dollars invested in the stock exchange and yearly grants for about 2 billion dollars in global
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health (US$1.98 billion in 2011) the Gates Foundation is the largest individual financial contributor to global health behind the US, whose contributions are equivalent to 7 per cent of the total amount of development assistance in health (IHME 2014). As mentioned above, it is the second largest contributor to WHO’s total budget, substantially contributes to several GPPPs, and sits on various boards including of the GFATM and the GAVI. Besides considerations about the heavy influence of the Gates Foundation on global policies, in recent years the contradiction between its health mission and the fact that grant money is generated from investments in industries whose processes and products may have very negative impacts on health, such as Coca Cola, Exxon, and Monsanto, has been highlighted. Similarly palpable conflicts of interests exist between the Foundation and bio-medical industry (Birn 2014; Ricciuti 2014).

Finally, the scenario for other transnationally acting non-profits is highly diversified and complex. The sector includes subjects that differ greatly in nature, cause and membership. The distinction is often made between Public interest International NGOs (PINGOs), such as Médecins sans Frontières, Oxfam or Medicus Mundi International, and Business interest International NGOs (BINGOs), such as the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA). Civil society organizations (CSOs) also connect in transnational networks, which play an important role in advocacy and monitoring for governments and international institutions, giving voice to small CSOs. The Peoples’ Health Movement (PHM), for example, develops a systematic monitoring of WHO governance through its “WHO Watch” and publishes a Global Health Watch report every two years (PHM 2014).

Global Health policies are certainly also influenced by academia and the debate in the epistemic community. The Lancet, one of the most authoritative medical journals, has become an opinion leader in global health, hosting several series and mobilizing task forces on specific transnational issues. The 2014 Manifesto calling for a new approach to “planetary public health” is a good example (Horton et al. 2014).

Transnational hybrid organizations and initiatives

Over the past decades, the interactions between international institutions and NGOs have considerably increased and progressively extended to other transnational private actors such as Global Philanthropy and the corporate sector. These interactions have spurred global initiatives and action networks, establishing new forms of transnational public–private hybrids and substantially contributing to the fragmentation and complexity of global governance. Varying from relatively informal alliances to highly structured organizations, most of these multi-stakeholder initiatives share a vertical, technological and quick-fix approach to single issues, and lose sight of the complex, structural causes at the origin of a problem. Without a constitutive international agreement (as is the case for international institutions), most initiatives follow two organizational alternatives. A number of GPPPs are hosted by international institutions. Although they have various degrees of autonomy, these hosted partnerships are not separate entities legally and tend to present a burden for the host institution, and sometimes a cause of conflicting relations. Examples are UNITAID, Stop TB and, initially, the GAVI alliance.

The alternative to being hosted is establishing the GPPP itself as an autonomous private organization (although with public and private representation in governing bodies) incorporated according to the national law of the host country; both the GFATM and GAVI are private Swiss foundations. Nevertheless, thanks to the creative and flexible use of legal instruments both were able to obtain the privileges of international institutions from the Swiss government (Missoni 2014).
The Global Alliance on Vaccines and Immunizations (GAVI) was launched in 2000 with an initial contribution of US$750 million from the Gates Foundation. Today its yearly grant is above US$1 billion (IHME 2014). GAVI represented the most advanced prototype for GPPPs. Hosted by UNICEF until 2009, it is currently a Swiss foundation and is recognized as a public charity in the United States. Its mission is the distribution of new or underutilized vaccines to children in developing countries. In addition to the Gates Foundation, international institutions such as WHO, the World Bank and UNICEF as well as a dozen of other subjects including governments, international NGOs and representatives of the pharmaceutical industry sit on the board with full voting rights.

GAVI also became the channel for innovative financing mechanisms for the development and distribution of medical products such as the International Financing Facility for Immunizations (IFFIm) and the Advance Market Commitment (AMC). IFFIm issues bonds, which are guaranteed by the long-term commitment of participating governments. Sold on the financial market, they generate consistent amounts of capital to be spent in advance for GAVI’s activities. With the AMC, participating governments pledge availability of funds that will assure bio-medical manufacturers a stable, long-term market for products, which otherwise would have no adequate market, thus incentivizing related research and development (Le Gargasson and Salomé 2010).

GAVI was the model for the GFATM, which today occupies a central position on the global health stage, financing initiatives for the control of the three diseases with over US$3 billion annually (IHME 2014). It was incorporated from the beginning as a Swiss private foundation, but it operated as a trust fund managed by the World Bank and with an administrative services agreement with WHO, who acted as its Secretariat until 2009, when the agreement was terminated. Despite the declared purpose of attracting private funds, the GFATM still relies on governments’ contributions for more than 95 per cent of its funds. Nevertheless, the private sector is represented on the board with full voting rights and the WHO is a non-voting member. Although it has been observed that the GFATM contributed to reducing the price of antiretroviral drugs and bed nets in low- and middle-income countries, its activities at the global level (monitoring, surveillance, data collection, etc.) often overlap with those of the WHO (Blanchet et al. 2014), whose authority and mandate may be undermined by GPPPs such as the GFATM and the GAVI.

A nascent experiment in the late 1980s, GPPPs are now part of mainstream development discourse and a dominant model for cooperation in a complex world. The efficiency and the effectiveness of the model remain, however, controversial.

Conclusions

An increasing number of international institutions and transnational organizations have contributed over the last two decades to deeply modify the global health governance map. However, we have barely mentioned the complexity of actors and interactions impacting the vast array of social, economic, environmental and political determinants of health, which should be considered in the attempt to draw a more comprehensive map of governance for health.

Global health is increasingly determined by economic and trade policies developed under the powerful influence of TNCs, thus weakening the firewalls necessary for effective regulation and normative actions at both global and national levels. The UN, and specifically WHO, seems to have lost sight of its mission and purpose, and fails to advocate on issues that challenge the profit motives and market logic of companies.

It is precisely in the field of governance for health that a new normative and ethical framework will have to be built to face today’s unprecedented health challenges and inequities.
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Notwithstanding the many health actors with global scope, WHO remains the only multilateral institution with the political legitimacy and dedicated mandate to promote and protect health. However, there is no doubt that it needs to be empowered in that leading role, supported by the necessary resources, trust, and possibly by new international legal frameworks, as well as a redefined scope of global governance with the sole interest of public health and peoples’ right to “the attainment of the highest possible level of health”.

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