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Editorial

Global Health Governance Challenges 2016 – Are We Ready?

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Abstract

The year 2016 could turn out to be a turning point for global health, new political realities and global insecurities will test governance and financing mechanisms in relation to both people and planet. But most importantly political factors such as the global power shift and "the rise of the rest" will define the future of global health. A new mix of health inequity and security challenges has emerged and the 2015 humanitarian and health crises have shown the limits of existing systems. The global health as well as the humanitarian system will have to prove their capacity to respond and reform. The challenge ahead is deeply political, especially for the rising political actors. They are confronted with the consequences of a model of development that has neglected sustainability and equity, and was built on their exploitation. Some direction has been given by the path breaking international conferences in 2015. Especially the agreement on the Sustainable Development Goals (SDGs) and the Paris agreement on climate change will shape action. Conceptually, we will need a different understanding of global health and its ultimate goals - the health of people can no longer be seen separate from the health of the planet and wealth measured by parameters of growth will no longer ensure health.

Keywords: Global Health, Governance, Sustainable Development Goals (SDGs), Development, Power Shift, Sustainability, Humanitarian Crisis, Climate Change

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A Changing Context for Global Health

The 2015 was a critical year for setting ambitious new global agendas and it put global health on the political agenda of heads of state. But it was also a year of destabilization and crisis that has raised questions whether the post-World War II international organisational structures will be able to deal with the growing insecurities the world faces. In the view of many critics the United Nations (UN) – now in its 70th year – no longer deliver in the face of new political realities and complex trans-border risks. This includes a critical view of present mechanisms of global health governance.

While concern about the ecological crisis has been with us for some time, at the beginning of 2015 the financial crisis was still very much in focus, during the year the humanitarian emergency moved to the centre. In view of mass migration and the growing refugee crisis the US Permanent Representative to the UN, Samantha Power stated that *"this year has shown with painful clarity that our existing systems, approaches and funding are inadequate."*[1] In global health, this deep feeling of uncertainty and institutional inadequacy was present throughout the Ebola outbreak. The World Health Organization (WHO) was severely criticized, the existing global instrument (the International Health Regulations, IHR) was considered inadequate and countries needed to face a tough decision whether the WHO should remain the agency assigned to deal with matters of global health security.[2]

Looking back over the last 15 years we often speak of a golden era of global health.[3] In order to achieve the three health Millennium Development Goals (MDGs) new mechanisms of global health governance were put in place, such as the The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), GAVI or the Joint United Nations Programme on HIV/AIDS (UNAIDS). They could rely on a highly committed and relatively stable donor environment and little competition from other global issues. Most importantly a novel dynamics was created in global health through the resources and approach of the newly created Bill and Melinda Gates Foundation and the advocacy of strong civil society actors committed to the MDG priorities. At present we witness an apparent paradox - while the political attention to global health issues has increased - especially since the Ebola outbreak - other trends push in the opposite direction. The support of Western donors to global health development aid is stagnating, some of the complex issues to be resolved – for example in global health security – have no strong civil society backing and there is no lack of competing global challenges.

A New Approach to Global Governance?

Purdy[4] outlines in his analysis of the politics for the anthropocene era that "The only way to build a shared living space deliberately is through politics." Faced with major crisis multilateralism delivered in this year of crisis and four key international conferences reached consensus on a way forward in global problem solving:

- the Third International Conference on Financing for Development in July 2015 adopted the *"Addis Ababa Action Agenda"*[5];
- the UN Summit in September 2015 adopted the post-2015 development agenda and agreed on seventeen *Sustainable Development Goals* (SDGs)[6];

- the 2015 UN Climate Change Conference (COP21) adopted the *Paris agreement*,[7] the first-ever universal, legally binding global climate deal; and
- the World Trade Organization Ministerial Conference, also in December 2015, adopted the *Nairobi Package*[8] with a focus on agriculture, with the aim to support the least-developed countries.

The goal of the global health community is usually to get health on the agenda of such major conferences and it judges them successful if they deliver – preferably binding – commitments for advancing global health and its determinants, especially in terms of responsibilities and financing. But it might be even more critical for the future of global health governance to assess the extent to which these 2015 conferences set signals for global governance far beyond specific issues. Ethiopian Prime Minister Hailemariam Desalegn, president of the Addis Ababa Conference set the tone for the conferences to follow: *"the only development worth having is sustainable development."*[9]

I have already mentioned that the successful completion of these conferences in itself sends a strong message on multilateralism, even if for many they may not have gone far enough. Other messages common to these agendas emerged that will also need to be considered in upcoming global health negotiations:

- the development partners must engage in a new type of multilateralism that acknowledges and reflects both the diversification of global power and the need to act together;
- the North-South divide must be overcome through taking on joint but differentiated responsibilities;
- priority must be given to an integrated development agenda that includes social needs and environmental concerns;
- innovative development finance and "smart investment" is gaining ground over development aid; and
- the approaches to development need to ensure a new balance between domestic and global action while recognizing the commitment to common goals, as reflected in the SDGs.

The negotiations reflected the multipolar world and were – as all parties confirm – difficult and challenging; for example both Nairobi and Paris required an extra day of intensive negotiations to conclude. *"Tough calls had to be made but we did bite the bullet"* said the chair of the Nairobi Conference, Kenya's Cabinet Secretary for Foreign Affairs and International Trade, Amina Mohamed.[8] In the negotiations for the Paris agreement 2015 the power shift and the economic interests at stake were tangible and the difference to the failed Copenhagen negotiations of 2009 could not have been greater. Anne-Marie Slaughter[10] has suggested that the Paris agreement might serve as a model for effective global governance in the twenty-first century.

She calls it "*a bold move toward public problem solving on a global scale*" and identifies several crucial points: it

- substitutes rolling processes for fixed rules;
- relies on bottom-up Intended Nationally Determined Contributions (INDCs), which require the citizens and governments of each individual country to come together to determine what they can reasonably achieve;
- is based on collectively supported competition not only between countries, but also other entities such as cities;
- proposes a transparent compliance mechanism which is built on "expert-based" assessment teams and implementation support;
- is addressed not only at governments, but calls on many other entities to play a major role; and
- includes a finance mechanism – the Green Climate Fund.

These points deserve serious consideration in the debate on global health governance, where the preferred option for many is still a legally binding agreement – for example as the global health community revisits the IHR, discusses a potential global agreement on antimicrobial resistance (AMR) at the next United Nations General Assembly (UNGA) or argues for a Framework Convention on Global Health.[11]

New Political Dynamics

The negotiations at these four gatherings are a sign of what Fareed Zakaria[12] has summarized as the key change in world politics: "the rise of the rest." "On every dimension other than military power—industrial, financial, social, cultural—the distribution of power is shifting, moving away from US dominance" he says. As the world becomes more multipolar, the power shift and flexible alliance building begins to reflect on institutions and mechanisms of global governance in relation to many different issues, also on global health. A much wider range of countries now possesses the means that are constitutive for participation in global governance: endogenous resources, transnational connectivity, and geopolitical status.[13] Perspectives also need to change fast: Africa is now the second fastest growing region behind Asia and some countries like Mozambique, Ethiopia, and the Democratic Republic of the Congo are among the fastest growing in the world.[14]

The new global marketplace of political change[15] is highly relevant for future global health governance and financing. The power shift has led to the creation of new financial institutions such as the Asian Infrastructure Investment Bank as well as the New Development Bank BRICS – Brazil, Russia, India, China, and South Africa – (NDB BRICS).[16] The latter is explicitly described as *"the birth of a new non-Western financial model"* which will not create strict political conditions for giving loans. The Organization for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) model of dividing the world into donors and recipients or subjects and objects of development is not attractive for many new economic powers and they do not want to "graduate" from one bloc to the other. It suits their purpose that the global diffusion of power leaves attributions vague, as this opens many more possibilities for influence and alliance building. Their choice of South-South cooperation as a preferred mechanism is due to many factors ranging from joint histories of colonialism, hard economic interest and new soft power strategies, which include a revisiting of traditional links such as Buddhist diplomacy by India, the New Silk Road diplomacy by China and the link to lusophone countries by Brazil.

Much of the achievement of SDG 3 on health will rest on the shoulders of the emerging market economies – the BRICS alone comprise 46% of the world's population, add some of

the MINT countries (Mexico, Indonesia, Nigeria, Turkey) and we have the majority of the world population rapidly on the way to global health convergence,[17] as most experience a rapid epidemiological transition and population ageing. The largest number of poor people also live in these countries and health inequalities loom large. The BRICS combined gross domestic product (GDP) is US$16 trillion and their political decisions will be critical for progress in global health: the extent to which they will invest in health both at home and abroad, through which financing channels they will choose do so and which type of health systems they will favour. In Johannesburg, Republic of South Africa (RSA) in December 2015 Chinese President Xi Jinping announced an investment in Africa totalling $60 billion.[14] His country will roll out 10 major plans to boost cooperation in the coming three years, one of them being public health. This health cooperation plan covers seven priority areas including post-Ebola reconstruction health system infrastructure needs, training opportunities, and building research facilities.

The emerging economies countries fully understand the political, economic, and social value of good health; for example the BRICS countries have agreed to cooperate in the health sector and to promote progress towards universal and equitable access to healthcare, ensuring affordable, good quality service delivery - not only within their own countries but by supporting one another as well as developments elsewhere, especially on the African continent. This will lead to new types of relationships because in doing so they will be contributing to a significant surge not in donor money but in the global health industry. Accordingly the interest of the DAC donors is also shifting from aid to investment strategies referred to as commercial diplomacy - so that their industries can participate in this bonanza. For example, pharmaceutical sales in China[18] are predicted to increase from $65.77bn in 2011 to $143bn by 2016.

From the global health perspective it is critical to analyse how new money, new institutions, different goals and another way of strategic thinking will shape global health governance, its values and approaches. The alliances forged through South-South cooperation will surely play a part in the diplomatic goal set by the African continent to gain the election to the position of the Director General of the WHO in 2017. But there is also a larger question: how will the political and economic changes under way influence support for the WHO, the GFATM, GAVI, UNAIDS and many of the global health initiatives, which were shaped without strong participation from the global south? If the consultations on the framework of engagement with non-State actors (FENSA)[19] or lesbian, gay, bisexual, and transgender (LBGT)[20] at the WHO are any indication, negotiations will get more difficult.

Reconsidering Models of Health Development

Despite increasing globalization, we do not live in a global village: interdependence is no guarantor of an equitable relationship.[21] The transformation towards a sustainable and equitable world is a common challenge of all countries in the context of the implementation of the SDGs and the Paris agreement - the call to deal with both people and planet. The political dynamics are of course inextricably linked to the economic dynamics of globalization and the winners and losers that have emerged in a neoliberal era. This relationship has been highlighted in the report of the Lancet-University of Oslo Commission on Global Governance for Health.[22]

It seems obvious that we will need to reconsider our approaches to global health in view of the changed political and economic environment and the ecological challenge. In 2002, I suggested that the term Global Health "stands for a new context, a new awareness and a new strategic approach in matters of international health" and I proposed that its "goal is the equitable access to health in all regions of the globe."[23] Nearly 15 years later the new context of global health is defined first and foremost by the global diffusion of power, the new awareness requires an understanding of the interface between the ecological crisis, the financial crisis, the health security crisis and the crisis of social dislocation. The approaches favoured at present fit with the new flexible and hybrid multilateralism outlined above. Today the goal of global health goal requires an integrated approach which aims at "*Safeguarding both human health and the natural systems that underpin it.*"[24]

Sociological conceptualizations of the global risk society[25] highlight that many of the risks we deal with in the 21st century are related to both unintended and neglected consequences of progress and change, a chain of secondary effects on which we are now required to act. This means dealing with *"the combined impacts of rapid demographic, environmental, social, technological and other changes in our ways-of-living."*[26] In global health for example one of the most worrisome developments is the increasing threat of AMR in human, animal health and plant health, due to overuse of antibiotics. This threatens to make one of the most important discoveries in medicine useless. Another example is the crisis of noncommunicable diseases (NCDs), set out to ravage the health gains of the emerging economies and linked deeply to unsustainable production and consumption. Health no longer automatically follows wealth[3] and much of the progress in health "*has so far been achieved at the price of increased CO2 emission that drives the imminent climate crisis.*"[27] We are faced with a "new landscape of inequality"[4] which also finds its expression in the concentration of wealth and power in fewer hands.

But we have not only failed the planet and have not addressed the health inequity and security challenges head on - we have also failed the most vulnerable: populations in fragile states, victims of war, refugees, asylum seekers, trafficked populations, people in forced labour, slaves, and global migrant workers. The number of people affected by crises around the world has almost doubled over the past decade. Sixty to 80 million people have had to leave their homes and the UN peacekeeping, United Nations Human Rights Council (UNHRC) and World Food Programme (WFP) response systems have reached their limits. Aid to poor and fragile states has stagnated since 2009 yet 90% of people in extreme poverty are living in countries that are politically fragile, environmentally vulnerable or both. As a response to the "rise of the rest" many donor countries and aid agencies are revisiting their focus and approach and many are reducing their aid commitments. There has also been a move in some of the largest contributor countries to redirect foreign aid budgets to pay for supporting asylum seekers arriving in the

country.[28] The shift in development strategies is palpable as in the new UK development policy[29] and there is much concern in the development community that the focus on national interest and foreign policy goals will come at the expense of fighting poverty and inequality.

Long standing international agreements such as the UN Convention and protocol relating to the status of refugees[30] and the Geneva Conventions[31] (which form the core of international humanitarian law) are being put aside and questioned. Some also consider the complete separation between humanitarian and development funding "complete madness."[32] As development actors move out of middle-income Countries (MICs) and propose to scale up their bi-lateral investments in conflict-affected and fragile states, the humanitarian community is desperately seeking funds to work in those very countries. Critics state: "*What we have in the aid sector is equivalent to a completely independent ambulance service with no connection whatsoever to a hospital. It is looking for money where it can get it, to set up an ambulance service where it thinks it is needed, based on its own assessment of the injuries. That doesn't make sense.*"[32] In global health the Ebola crisis showed up all the weaknesses inherent in such a messy system.[2]

Two World Summits in 2016 are going to review this dire situation: the first ever World Humanitarian Summit[33] as well as a high-level summit on the global refugee crisis at the UN General Assembly hosted by the United States President Barack Obama. Hopefully they will not only gain the attention they deserve but take us a step further in the conceptualization of global governance through an integrated approach, not be reinforcing separate worlds of development and humanitarian response. Global health must use these platforms and contribute with a new focus on the global flow of people and the health rights of the marginalized and disenfranchised millions, for whom no state takes responsibility. Existing institutions will need to include new areas of work; possibly new institutions and funding mechanisms will have to be created both within countries and at the regional and global level.

Conclusion

Thirty years ago "AIDS changed everything" and a new era of global health was born, based on social movements, scientific ingenuity, philanthropic commitment and global solidarity. Fifteen years later UNAIDS[34] and the GFATM can speak of ending the AIDS epidemic as a public health threat by 2030. A similar global effort must go into promoting a 21st century concept of global public health in the SDGs context which is democratic and ecological rather than utilitarian. Purdy[4] develops the political goal of a "democratic anthropocene" which responds to the new landscape of inequalities by bringing together "certain questions that we have called ecological and others we have called humanitarian, questions of conservation and questions of justice." What approaches to global health governance emerge if we accept such a seminal shift? Will we need new institutions? What governance mechanisms will be the most effective?

Some direction has been given by the path breaking international conferences in 2015. Especially the agreement on the SDGs and the Paris agreement on climate change will define future action, also in global health. They will be supplemented by two conferences in 2016 that will deal with the most disadvantaged people and debate a reshaping of the humanitarian system. Their outcomes will impact even further on our concepts of development and development finance, but also of the interface between humanitarian health approaches, health security and health action in fragile states as well as the rights of refugees and victims of war. How will our global health concepts hold up in the face of millions of people on the move as they challenge borders, financing mechanisms, social systems and political positions?

One popular answer in the face of multiple global crisis has been to promote resilient systems including universal health coverage and sustainable systems for health as the next big evolution in global health.[35] But such approaches do not go far enough in addressing the "causes of the causes"[36] of the ecosystems stress both humans and the planet are experiencing, as well as the high levels of inequality that come with it. Conceptually, we do need a different understanding of global health and its ultimate goals - we cannot see the health of people separate from the health of the planet and we must understand the interface of health and wealth in new ways. In the 1970s a classic book provided council on how to provide healthcare "Where there is no doctor"[37] - the 2016 version will probably ask how to provide health "Where there is no state."

The challenge ahead is of course deeply political. The rising political actors are confronted with the consequences of a model of development that has not only neglected sustainability and equity, but was built on their exploitation. This originally Western model of expansion has recently created tremendous wealth as well as rising inequalities the emerging economies. Today its consequences put both the health of people and planet and the survival of all at risk, as the smog levels of Beijing and Delhi document. It raises the key question that defined all four major conferences in 2015 and will continue on into 2016 beyond: how will responsibility for our future be distributed as power is diffused? What political mechanisms will we have at our disposal? Can the commitment to the SDGs help build a new UN? Will the new powers want to support multilateralism? Will concepts of ecological public health facilitate a new agenda? I hope journals such as this as well as the many global health conferences that are organized all over the world every year will take some of these questions forward.

Ethical issues

Not applicable.

Competing interests

Author declares that she has no competing interests.

Author's contribution

IK is the single author of the paper.

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