

GLOBAL GOVERNANCE AND PUBLIC HEALTH SECURITY IN THE 21ST CENTURY

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No State, no matter how powerful, can by its own efforts alone make itself invulnerable to today's threats.¹

I. INTRODUCTION

Governance is not the same as government; rather, it is a broader concept necessary to address the complex issues of a globalized world, a world where sovereign nations cannot individually respond to problems that span national borders. In health, global governance is changing in response to the globalization of diseases, the shifting power structures of government, the concern for security in a politically unstable world, the weakening of international organizations, and the increasing roles of civil society and the commercial sector in global health. Global health governance is necessary for society to “steer” itself to achieve common goals.² It involves rules, norms, principles, and procedures to structure

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1. The Secretary-General, *A More Secure World: Our Shared Responsibility: Report of the High-level Panel on Threats, Challenges and Change*, ¶ 24, delivered to the General Assembly, U.N. Doc A/59/565 (Dec. 2, 2004) [hereinafter *A More Secure World*], available at <http://www.un.org/secureworld/report.pdf>.

2. Kent Buse & Kelley Lee, *Business and Global Health Governance* (Key Issues in Global Health Governance Discussion Paper No. 5, at 14, Dec. 2005).

cooperation, and it is effective only with the agreement and compliance of both governors and the governed.³

In December 2004, the United Nations issued *A More Secure World: Our Shared Responsibility: Report of the High-level Panel on Threats, Challenges and Change (A More Secure World)*, a follow-up report to the Millennium Summit, where commitments to global cooperation were made in response to several major health and development challenges.⁴ This report emphasized the need to achieve the Millennium Development Goals (Table 1), with a focus on health and biological security.

Table 1. The United Nations Millennium Development Goals for 2015⁵

1. Eradicate extreme poverty and hunger;
2. Achieve universal primary education;
3. Promote gender equality and empower women;
4. Reduce child mortality;
5. Improve maternal health;
6. Combat HIV/AIDS, malaria and other diseases;
7. Ensure environmental sustainability; and
8. Develop a global partnership for development.

The focus of the U.N. report extends to the social determinants of health (especially poverty and economic inequities), infectious diseases, and environmental degradation.⁶ Although sovereign states are the front line in dealing with health threats, the report emphasized that no state can stand wholly alone and that collective strategies, collective institutions, and a sense of collective responsibility are indispensable in addressing the global health challenges of the twenty-first century.⁷ Indeed, governments have begun to align themselves in new agreements such as in the 2007 Oslo Declaration, wherein the Ministers of Foreign Affairs (*not* of Health) of Brazil, France,

3. *Id.*

4. *A More Secure World*, *supra* note 1, ¶ 57.

5. U.N. Millennium Development Goals, <http://www.un.org/millenniumgoals> (last visited Sept. 23, 2007).

6. *A More Secure World*, *supra* note 1, ¶¶ 44, 47, 53.

7. *Id.* pmbl.

Indonesia, Norway, Senegal, South Africa, and Thailand recognized the need for new forms of governance to support development, equity, peace, and security.⁸

With the growth of civil society and the enormous new funding for global health from the private sector, new concepts of governance involving non-state actors are needed. Not all of this assistance has been unconditionally accepted, and may in fact present significant complications in global health governance.⁹ In addition, academia has seen the growth of training, research, and service programs in global health that respond to concerns about social justice and emerging global health threats.¹⁰ Health professionals and students throughout the world feel a need to respond to these challenges, and there is now a clear challenge to join health and foreign policy disciplines together in preparing the next generation of global health professionals.¹¹

This essay addresses the following issues related to global governance and public health security in the twenty-first century:

- Globalization as a driving force for global governance in health;
- Opportunities and limits for multi-national actions on global health;
- Health as a human security issue; and
- Foreign policy options in the new era of global health governance.

II. GLOBALIZATION AS A DRIVING FORCE FOR GLOBAL GOVERNANCE IN HEALTH

Globalization refers to a broad range of issues regarding the movement of information, goods, and services through print and electronic media and trade liberalization, and to the movement of

8. Oslo Ministerial Declaration, *Global Health: A Pressing Foreign Policy Issue of Our Time*, 369 LANCET 1373-78 (2007).

9. Laurie Garrett, *The Challenge of Global Health*, 86 FOREIGN AFF. 14, 14 (2007).

10. Thomas E. Novotny, *Education and Careers in Global Health*, in UNDERSTANDING GLOBAL HEALTH 318-19 (William H. Markle et al. eds., 2007).

11. Ilona Kickbusch et al., *Global Health Diplomacy: Training Across Disciplines*, BULL. OF WHO (forthcoming 2007) (manuscript on file with author).

people through migration and global travel.¹² Much also has been written on the global effects of environmental degradation, population growth, and economic disparity. In addition, the pace of scientific development has accelerated, with both negative and positive implications for global health. Concerns for health transcend national borders, and sovereign nations must have a global approach to assure health security for their citizens. In 1997, the Board on International Health of the U.S. National Academy of Sciences' Institute of Medicine described in a report, entitled *America's Vital Interest in Global Health*, how the United States must protect its own people, improve its economy, and advance its international interests through engagement in global health.¹³ Further, the board affirmed that all developed countries can benefit similarly through active and coherent cooperation.¹⁴ This approach may represent enlightened self-interest, but it also asserts a set of humanitarian goals and moral values for foreign policy.

International labor movements, deepening economic disparities, political strife, and loss of sustainable agricultural resources have dramatically increased the movement of people across national borders, perhaps causing as many as one million transits per day. In addition, the rapidity of global travel, combined with the growth of the global population, permits human contact around the world in a matter of hours compared with a matter of months a century ago (Figure 1). Health of domestic populations may be threatened by emerging infectious diseases, drug-resistant pathogens, contaminated food supplies, chemical and biologic attacks, and even by the cross-border advertising and marketing of harmful substances such as tobacco and alcohol.¹⁵ Even though health is ultimately the responsibility of

12. Thomas E. Novotny et al., *Bioethical Implications of Globalization: An International Consortium Project of the European Commission*, 3 PLOS MED. 173, 173 (2006).

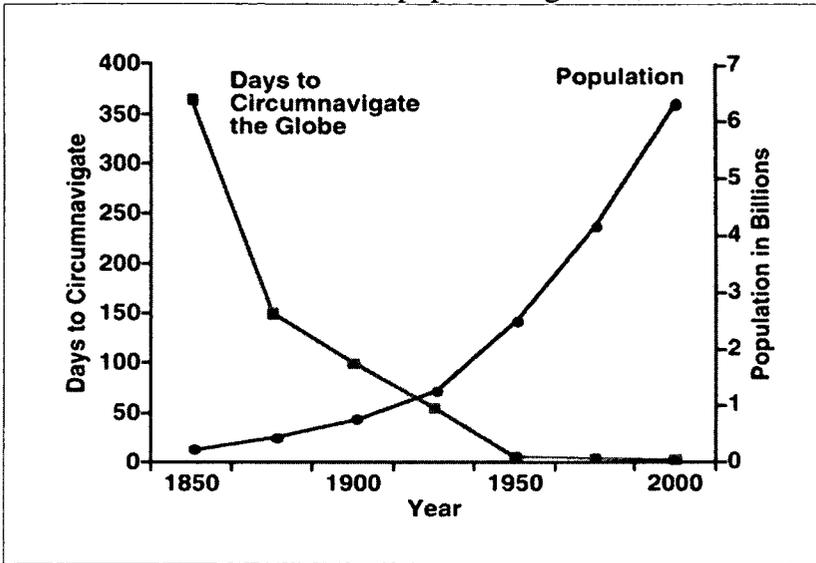
13. AMERICA'S VITAL INTEREST IN GLOBAL HEALTH: PROTECTING OUR PEOPLE, ENHANCING OUR ECONOMY, AND ADVANCING OUR INTERNATIONAL INTERESTS 4 (Bd. on Int'l Health, Inst. of Med. 1997) [hereinafter VITAL INTEREST].

14. *Id.*

15. Christopher P. Howson et al., *The Pursuit of Global Health: The Relevance of Engagement for Developed Countries*, 351 LANCET 586, 586 (1998) (discussing the health threats posed by globalization and advocating increased involvement of industrialized countries in promoting global health).

sovereign nations, the protection of domestic populations now demands international cooperation and invigorated global governance to support such cooperation.¹⁶

Figure 1. Global travel and world population growth, 1850-2000



The global health community now extends far beyond government. It includes: private or commercial entities (multinational corporations); academia; non-governmental organizations such as private foundations, humanitarian groups, and advocacy organizations; multilateral organizations such as the World Health Organization (WHO), the World Bank, and the U.N. development agencies; and bilateral aid structures such as the U.S. Agency for International Development, the Swedish International Development Agency, and the Japan International Cooperation Agency. Given this panoply of players, a state-centric approach to health is inadequate given the new financial resources for global health and cross-border nature of today's public health challenges.

Indeed, private-public partnerships now abound (examples include the STOP TB Initiative; the Multilateral Initiative on Malaria;

16. David Fidler, *Global Health Governance: Overview of the Role of International Law in Protecting and Promoting Global Public Health* (Key Issues in Global Health Governance Discussion Paper No. 3, at 47, May 2002).

and the Global Fund for AIDS, TB and Malaria). These initiatives are largely uncoordinated and are directed at specific high-profile diseases rather than at health infrastructure development or public health in general. They are in large part fueled by huge infusions of cash from charitable institutions such as the Bill and Melinda Gates Foundation, which had provided \$6.6 billion for global health programs as of 2006.¹⁷

In addition, the World Bank is now the largest multinational health development agency, providing an average of \$2 billion per year for health programs.¹⁸ The World Bank embraced health as a major development issue beginning in the late 1980s, and solidified its leadership (some say at the expense of the WHO) with its 1993 *World Development Report*.¹⁹ This report proved influential on Gates and others who turned their attention to global health.

David Fidler, in *Global Health Governance: Overview of the Role of International Law in Protecting and Promoting Global Public Health (Global Health Governance)*, developed a useful model to display the complexity of global governance in today's world.²⁰ Fidler differentiates international from global: international agreements occur between nations, and global interactions include all the other non-state and multinational organizations (Figure 2).²¹

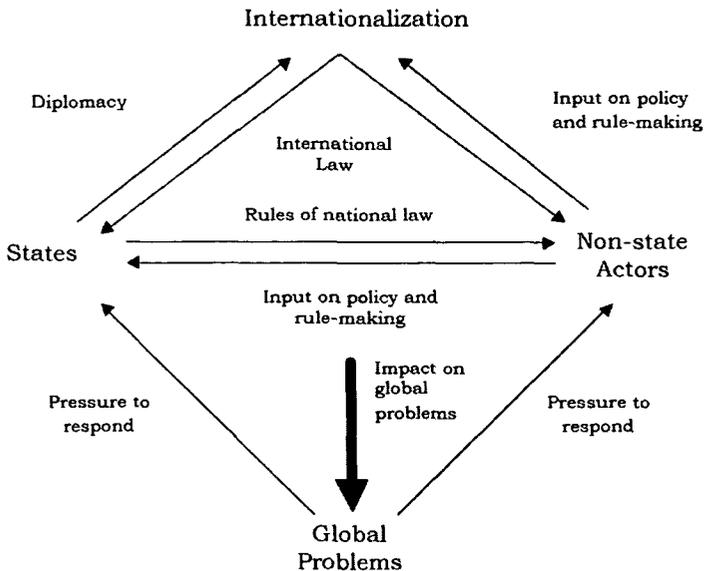
17. Garrett, *supra* note 9, at 14.

18. *Id.*

19. See generally WORLD BANK, WORLD DEVELOPMENT REPORT 1993: INVESTING IN HEALTH (1993) (discussing a three-pronged approach to health investment, including shaping positive household health decisions, increasing government spending on health, and promoting diversity and competition in the provision of health services).

20. Fidler, *supra* note 16, at 9.

21. *Id.* at 8-9.

Figure 2. A schematic of global health governance²²

One might ask, just how do these myriad actors fit together in common purpose for global health? Do the multilateral organizations provide sufficient governance structure to coordinate, govern, and monitor the activities of these actors? What is the role of the state in this governance scheme?

III. OPPORTUNITIES AND LIMITS FOR MULTINATIONAL ACTIONS ON GLOBAL HEALTH

Fidler has asserted that legal systems provide the core architecture for governance, and a strong legal and structural framework in global health is increasingly important given the current institutional chaos.²³ Although traditionally recognized as the primary multinational global health agency, the WHO lost much of its strength under limits imposed by major nations and the increasing influence of the World Bank in the 1980s. In addition, the WHO had little interest in international law, since most international agreements were perceived to be outside its competency. These agreements included environmental treaties (such as the Kyoto Protocol on Greenhouse

22. *Id.* at 9.

23. *Id.* at 7.

Gases), trade agreements (such as the General Agreement on Tariffs and Trade), and labor law (under the International Labour Organization (ILO)).²⁴ However, given the new complexities, the WHO is arguably more important than ever to global health governance, and it has tried to regain much of its purpose under recent reforms brought by Director Generals Gro Harlan Brundtland and J.W. Lee.

Although the constitution of the WHO recognizes the role of law in national public health, its core mission is to provide standards, practices, and technical recommendations for collaborative accomplishment of agreed-upon public health goals. Usually, these take the form of non-binding, consensus-based resolutions (so-called “soft law”) promulgated by the World Health Assembly (WHA) during its annual May meeting of member states. In addition, the WHO may develop binding legal agreements in the form of treaties among the member states. Two legal mechanisms—the International Health Regulations²⁵ and the Framework Convention on Tobacco Control²⁶—are now in place under Article 23 of the WHO constitution, which authorizes the development and implementation of such agreements by the member states.²⁷ In fact, these two legal structures may have been developed because of the observed failures of public health governance among sovereign states. Whether these structures succeed in their purpose, however, depends on national enforcement of the binding obligations within them. International

24. Framework Convention on Climate Change, Dec. 1-10, 1997, *Kyoto Protocol*, U.N. Doc. FCCC/CP/1997/CRP.6 (Dec. 10, 1997) (discussing agreement to reduce production of methane gas through proper waste disposal and treatment and to promote sustainable agriculture); General Agreement on Tariffs and Trade, Apr. 15, 1994, 1867 U.N.T.S. 187, 33 I.L.M. 1153; General Agreement on Tariffs and Trade, Oct. 30, 1947, 61 Stat. A-11, 55 U.N.T.S. 194; Int’l Labour Org., <http://www.ilo.org/global/lang-en/index.htm> (last visited Oct. 4, 2007).

25. World Health Org., Revision of International Health Regulations, WHO Doc. A58/4 (May 23, 2005) [hereinafter IHRs] (regulating the public health response to the international spread of disease so as to avoid unnecessary interference with international traffic and trade).

26. World Health Org., Framework Convention on Tobacco Control, WHA Res. 56.1 (May 21, 2003) [hereinafter FCTC].

27. World Health Organization Const. art. 23, available at http://www.who.int/governance/eb/who_constitution_en.pdf (last visited Oct. 5, 2007).

legal structures are necessary but not sufficient for global health governance; the state is still the entity responsible for assuring compliance.²⁸ For example, a recent case showed the potential weaknesses in the IHRs: an individual infected with multi-drug resistant tuberculosis traveled across several borders on several different commercial airlines before being appropriately quarantined. This was a test of the revised IHRs, and in this case, enforcement proved almost impossible, with deficiencies at several levels.²⁹ Additional national and multinational commitments are going to be necessary to fully implement the IHRs.

In addition, non-state actors are increasingly involved in the work of the WHO. This involvement may be through official recognition status, which permits groups having common interests with the WHO to speak at the WHA but not to vote on resolutions or governance issues. Such officially recognized groups may also be invited by the WHO Secretariat to provide commentary, consultation, or even text for resolutions to be considered by the WHA. On the negative side, another set of non-state actors may provide challenges to WHO governance. These include private entities that might attempt to influence both WHO staff and the officially recognized WHO affiliates. These entities may engage in political lobbying that may not be transparent and may even subvert WHO programs. One notable example is the effort of transnational tobacco corporations to obstruct the work of the WHO; this was exposed by a WHO Expert Committee in 2000, at the beginning of negotiations of the Framework Convention on Tobacco Control.³⁰

International law has been established in several areas of global concern: environmental change, humanitarian needs, human rights, bioethics, arms control, labor issues, and trade agreements. Clearly, many of these areas include health issues, but are grounded in intergovernmental organizations other than the WHO (e.g., the ILO and the World Trade Organization (WTO)). One major, recent

28. *Id.*

29. William H. Markel et al., *Extensively Drug-Resistant Tuberculosis: An Isolation Order, Public Health Powers, and a Global Crisis*, 298 J. AM. MED. ASS'N 83-86 (2007).

30. See THOMAS ZELTNER ET AL., WORLD HEALTH ORGANIZATION, TOBACCO CONTROL ACTIVITIES AT THE WORLD HEALTH ORGANIZATION: REPORT OF THE COMMITTEE OF EXPERTS ON TOBACCO INDUSTRY DOCUMENTS (2000).

development under the leadership of the WHO is the revision of the International Health Regulations (IHRs).³¹

A. *The International Health Regulations*

Communicable disease concerns drove the development of health regulations beginning with quarantine as far back as the fifteenth century. In the eighteenth century, sanitary treaties (e.g., the International Sanitary Conference of 1851) and then various Sanitary Bureaus regulated trade, goods, and the movement of people in order to control communicable diseases. The intent here was to sustain trade and commerce across borders, not necessarily to assure the health of populations. It was only later, in the context of humanitarianism and human rights, that such legal agreements addressed health issues directly.

The IHRs were established in 1969 to provide maximum protection against the international spread of disease and to assure minimal interference with world travel and trade.³² Initially, they focused only on yellow fever, cholera, plague, and smallpox. The WHO member states were the signatories to this agreement, which was implemented not as a direct treaty negotiation, but as a consensus process through the WHA. In 2005, the IHRs were revised by the WHO to focus on expanded public health risks of urgent international importance, taking into account international trade law and trade agreements related to disease prevention and control.³³ These became active in June 2007, and the IHRs now cover emerging infections such as Severe Acute Respiratory Syndrome (SARS), tuberculosis, and a new human influenza virus.³⁴ They also cover cross-border threats that arise from public health emergencies such as chemical spills, leaks and environmental dumping, or nuclear melt-downs.³⁵ Of critical importance in the IHRs is the inclusion of rules on global disease surveillance under the existing Global Outbreak Alert and Response System.³⁶ IHRs 2005 requires countries to improve

31. IHRs, *supra* note 25, art. 2.

32. Fidler, *supra* note 16, at 22.

33. IHRs, *supra* note 25, art. 2.

34. *Id.* annex 2.

35. IHRs, *supra* note 25, pmbl.

36. Global Outbreak Alert and Response System, <http://www.who.int/csr/>

international surveillance and reporting mechanisms for public health events and to strengthen their national surveillance and response capacities.³⁷ Under the IHRs, member states must harmonize their national policies, laws, practices, and regulatory actions to comply.

B. Other International Laws

International environmental laws address air pollution, biological diversity, ozone depletion, and climate change, generally under a framework treaty process. This is a formally negotiated general agreement that usually includes additional protocols to which the signatory parties may agree (or not agree) as legally binding obligations.

The International Covenant on Economic, Social, and Cultural Rights includes issues related to mental health, infectious diseases, and other conditions.³⁸ It affirms a goal of the highest attainable standard of physical and mental health, the basis for the 1978 WHO declaration (commonly known as the “Declaration of Alma Ata”) to achieve “health for all,” as a human right.³⁹ This Declaration presciently advocated for an intersectoral and multidimensional approach to health and development, including the increased involvement of civil society and education.⁴⁰ The WHO recently reaffirmed its commitment to “health for all” through twenty-one health targets for the twenty-first century.⁴¹

C. The Framework Convention on Tobacco Control

Non-communicable diseases (NCDs) account for sixty percent of the fifty-six million annual global deaths. Deaths from NCDs will

outbreaknetwork/en (last visited Oct. 4, 2007).

37. IHRs, *supra* note 25, art. 2.

38. International Covenant on Economic, Social, and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3, 6 I.L.M. 368.

39. Declaration of Alma-Ata, Int’l Conf. on Primary Health Care, Alma-Ata, USSR, arts. 1, 9 (Sept. 6-12, 1978), *available at* http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.

40. *Id.* art. 1.

41. World Health Organization, Health-for-all Policy for the Twenty-first Century art. 1, WHO Doc. A51/5 (May 11, 1998).

continue to increase with the aging of the global population and the spreading of risk factors such as smoking, poor diets, and obesity.⁴² NCDs are generally ignored in the IHRs, but other legal structures address them in the context of occupational health and safety, narcotic and psychotropic drug abuse, and environmental health. In 1999, the WHO began deliberations on the Framework Convention on Tobacco Control (FCTC), an agreement that contains general obligations and sets forth diplomatic channels to develop more specific binding protocols similar to the environmental frameworks mentioned above.⁴³ The FCTC aims to harmonize national efforts to reduce tobacco use as a trans-border health problem. To date, 168 countries have signed the FCTC, and of these, 147 have ratified it (notably missing from this list is the United States).⁴⁴ The FCTC focuses on demand reduction strategies such as clean-indoor air legislation, advertising restrictions, package labeling, and improved cessation services, as well as supply reduction issues related to tobacco smuggling and agriculture.⁴⁵

The spread of the tobacco epidemic is exacerbated by a variety of complex factors with cross-border effects including trade liberalization, direct foreign investment, global marketing, promotion and sponsorship, and the international movement of contraband and counterfeit cigarettes. Because of the complexities of the tobacco epidemic, the FCTC was a major breakthrough in global health governance. With the infusion of new moneys from the philanthropic community (including Bloomberg and Gates), the WHO and the member states that signed the FCTC may have an historic opportunity to control a truly cross-border NCDs risk. A unique feature of the FCTC's negotiating process was the purposeful inclusion of non-state actors in the deliberations. In fact, extraordinary attention has been paid by these non-state groups to the day-to-day process of treaty negotiation. The continued engagement among states, multilateral organizations, and civil society in such efforts may be an important new governance direction for global health in the twenty-first century.

42. Derek Yach et al., *The Global Burden of Chronic Diseases: Overcoming Impediments to Prevention and Control*, 291 J. AM. MED. ASS'N 2616, 2616 (2004).

43. FCTC, *supra* note 26, art. 3; Karen Slama, Editorial, *The FCTC Enters Into Effect in 2005*, 9 INT'L J. TUBERCULOSIS LUNG DISEASE 119, 119 (2005).

44. Slama, *supra* note 43, at 119.

45. FCTC, *supra* note 26, art. 6.

D. Limits and Challenges to the WHO

The WHO is an intergovernmental organization that exercises a mandate to improve global health.⁴⁶ The new WHO leadership, namely Director General Dr. Margaret Chan, is very aware that the external environment has changed, and with these changes, the WHO must address increased complexities in management and new governance structures. The WHO also recognizes the influence of donors, the World Bank, and new foreign policy strategies of the Organisation for Economic Co-operation and Development (OECD) countries on global health development. For example, the Global Fund for AIDS, TB, and Malaria (GFATM) is one of the new governance structures outside the authority of the WHO.⁴⁷ The GFATM has an executive director who answers to a board consisting of representatives of donor and recipient governments, non-governmental organizations, the private sector (including businesses and foundations), and affected communities. The WHO has an AIDS division that may provide specific technical recommendations, but the GFATM decides what, where, and when funding is supplied to national programs. Neither the state recipient nor the WHO is held accountable for any assistance provided by the GFATM. Clearly, such a structure is a challenge to the traditional global health governance of the WHO.

Indeed, the WHO has expanded beyond its reliance on Ministries of Health to include public and private sector actors through new consultation mechanisms and increased collaboration with the World Bank at the country level.⁴⁸ With the ability to mobilize large financial resources, World Bank loans for health programs and research activities significantly surpass WHO program budgets. Nevertheless, the WHO has been trying to maintain its role as a chief technical resource for member states.

46. Theodore M. Brown et al., *The World Health Organization and the Transition From International to Global Public Health*, 96 AM. J. PUB. HEALTH 62, 62-72 (2006).

47. Global Fund for AIDS, TB, and Malaria, <http://www.theglobalfund.org/en> (last visited Oct. 1, 2007).

48. Richard Dodgson et al., *Global Health Governance: A Conceptual Review* (Key Issues in Global Health Governance Discussion Paper No. 1, at 12, Feb. 2002).

One last important point to make about the WHO and other U.N. organizations concerns the influence of member states and donor agencies on WHO work programs. The WHO's \$3.3 billion operating budget for 2007 is comprised of country assessments (28%) and voluntary contributions (72%).⁴⁹ The WHO has authority only over the direction of the regular budget, and thus must heed the influence of voluntary contributors for the majority of its work program. In general, these voluntary contributions are directed to specific issues, and they may also have political or policy contingencies that supersede independent governance by the WHO. One particularly troublesome contingency is the Helms-Biden Agreement for Payment of Arrears to the United Nations.⁵⁰ In essence, this 1998 agreement "not only impose[d] conditions on the payment of arrears but also add[ed] new conditions to the payment of current US obligations to the UN regular budget, peacekeeping operations, and three UN specialized agencies (World Health Organization, Food and Agriculture Organization and International Labor Organizations)."⁵¹ Specifically, the agreement calls for a zero nominal growth budget for the WHO, wherein the regular budget must stay the same each year.⁵² Thus, the WHO must respond to the conditionalities of extra-budgetary sources mentioned above (now at 72% of the total WHO budget).

International technical assistance still is provided directly by the WHO and other multinational health organizations; however, much of this assistance is now financed through extra-budgetary contributions, as described above. Such contributions are usually accompanied by conditionalities, where donor priorities, politics, and values are imposed on recipient entities. This situation raises concerns about how agencies such as the WHO may accomplish their core missions. Large countries such as the United States, as well as foundations, tend

49. World Health Org., Working for Health: An Introduction to the World Health Organization, WHO 20 (2007), http://www.who.int/about/brochure_en.pdf.

50. The Helms-Biden Agreement is located in the Foreign Affairs Reform and Restructuring Act of 1998, H.R. 1757, 105th Cong. (1998); see also Steven A. Dimoff, *The Helms-Biden Agreement: An Analysis of Proposed Conditions Affecting U.S. Assessed Contributions to the United Nations*, UNA-USA, May 1998, <http://www.unausa.org/site/pp.aspx?c=fvKRI8MPJpF&b=475009>.

51. Dimoff, *supra* note 50.

52. *Id.*

to mandate performance guidelines from multinational organizations, including measurable outcomes and narrowly-targeted objectives. These all resonate with corporate-like governing boards, but these conditionalities make it difficult to govern recipient organizations, which are made up of member states. Further complexity is added at the country level for ministries and non-governmental organizations that must cope with both the largesse provided and their own organizational cultures and limited absorptive capacities.

The WHO depends on the participation, budgetary support, and multinational commitment of its member states. In the recent past, the United States severely criticized the WHO and other U.N. organizations, despite playing a major role in their establishment after World War II. Some of this criticism may have been justified, but the WHO is still the primary governance structure through which global health may be engaged by member states. Now, in the twenty-first century, it is clear that there is an increasing mandate for growing multinationalism, engaging with non-state actors, and strengthening U.N. organizations that serve the interests of global health. Further, these actions really serve the sovereign responsibility of nations to protect the health of their own people. The changing shape of global health governance calls for increased consideration of how all the various pieces fit together. Clearly, the WHO responded to these considerations beginning in the late 1990s by forming new partnerships, stakeholder alliances, and targeted multilateral programs such as STOP TB, Roll Back Malaria, and the Global Alliance for Vaccines and Immunization. It will be important for member states to support and strengthen the work of the WHO as the most important mechanism for global health governance in the twenty-first century.

IV. HEALTH AS A HUMAN SECURITY ISSUE

Beginning in the 1990s, significant attention developed towards global health threats in the United States and elsewhere. The previously cited *America's Vital Interest in Global Health*,⁵³ along with popular literature and news of new viral threats such as West Nile, Ebola, and SARS, led agencies such as the U.S. Center for Disease Control and Prevention and the Institute of Medicine to

53. VITAL INTEREST, *supra* note 13.

develop specific strategies to control emerging and re-emerging infectious disease threats. The global HIV/AIDS epidemic was described as a threat to international security, which led to significantly increased funding and resources dedicated to the low-income countries that bear the majority of the HIV/AIDS disease burden.⁵⁴ The significance of this threat and that of other infectious diseases was reaffirmed in a report by the Council on Foreign Relations, emphasizing that “the security of the most affluent state can be held hostage to the ability of the poorest state to contain an emerging disease.”⁵⁵

The WHO also joined the call to improve global health security. In 2007, World Health Day was dedicated to International Health Security.⁵⁶ In *Invest in Health, Build a Safer Future*, an official issues paper, the WHO asserted the need for coordinated action and cooperation among and within governments, the private sector, civil society, media, and individuals.⁵⁷ The paper argued for capacity-building in developing countries, the support of multiple stakeholders, and global preparedness for infectious disease emergencies.⁵⁸ In addition, the WHO highlighted the need to develop public health infrastructure as a global public good, with increased political goodwill and financial commitment to improve health security. Trade also was addressed as a component of health security, with attention given to providing drugs and services necessary to contain various global health threats.⁵⁹ Other areas of concern for health security include humanitarian assistance and donor coordination; chemical, radioactive, and biological terror threats; and environmental and climate changes that affect health.⁶⁰

In *Invest in Health, Build a Safer Future*, the IHRs were emphasized as a key tool to support international health security, with prompt reporting of disease outbreaks and collaboration among

54. LAURIE GARRETT, COUNCIL ON FOREIGN REL., HIV AND NATIONAL SECURITY: WHERE ARE THE LINKS? 12 (2005).

55. *Id.* at 55.

56. World Health Org., Issues Paper: *Invest in Health, Build a Safer Future 2* (2007), http://www.who.int/world-health-day/2007/issues_paper/en/index.html.

57. *Id.*

58. *Id.* at 18.

59. *Id.* at 6.

60. *Id.* at 8-13.

countries and networks for disease control.⁶¹ The WHO has increased technical capacity to monitor infectious and other disease threats as they are reported, and increased support to member states to help them develop surveillance capacity, laboratory backup, and communication among public health agencies. Finally, *Invest in Health, Build a Safer Future* specifically addressed the need to strengthen health systems as the “bedrock” of international health security.⁶² According to the paper, governments are key in this process, but multinational organizations, the private sector, and civil society are all stakeholders in this challenge as well.⁶³ For example, the Bill and Melinda Gates Foundation has provided substantial support for public health network development through academia and public health institutes across the globe.⁶⁴ The foundation’s \$20 million grant to the International Association of National Public Health Institutes will provide concrete tools for improving public health infrastructure and health security internationally through academic leadership and advocacy. Additional attention must be paid to governmental health system development, particularly in public health areas, which is essential to global health collaborative efforts.

There has also been increased attention by the global health community for physical security against violence, the threat of violence, and the resultant injury, death, psychological harm, and impaired development opportunities.⁶⁵ Security is an essential requirement for health development, and personal security is therefore seen as a human right in this context. To achieve this sense of security, the health sector, as well as the defense, foreign policy, and finance sectors, must be involved to form a nexus of necessity for defense. Armed violence, displacement of populations, natural and man-made disasters, and poverty are concerns for global health security and a challenge to global governance structures. Clearly, human security demands cooperation across unfamiliar sectoral

61. *Id.* at 16.

62. *Id.* at 18.

63. *Id.* at 2.

64. Press Release, Emory Health News, Emory, Finland Partner to Build Public Health Network with \$20M Gates Grant (Jan. 10, 2007), http://whsc.emory.edu/press_releases2.cfm?announcement_id_seq=8740.

65. Robin Coupland, *Security, Insecurity and Health*, 85 BULL. OF WHO 181, 181 (2007).

boundaries. Traditionally, security was a more national concern, but now, *human security* at the global level is rooted in the idea that security for all is linked to the physical and economic insecurity of even the most marginalized populations and distant, unstable political entities.⁶⁶

Finally, health security is dependent on sustainable development. This means that global health governance must focus on the underlying determinants of health, including economic inequities, environmental degradation and disasters, and, in particular, social determinants of health.⁶⁷ Many of these determinants fall outside the health sector and are related to “engines in society that generate and distribute power, wealth and risk.”⁶⁸ Economic asymmetry is inextricably linked to ill-health, including both infectious disease and NCD conditions. In response to this concern, the WHO established the Commission on Social Determinants of Health.⁶⁹ This commission will review not only existing knowledge, but also will engage debate and promote global policies that may reduce inequalities in health within and among countries. This may be the most significant challenge to global health governance among all challenges presented in this essay. Health and economic inequity solutions will involve major shifts in national priorities as well as investments in poverty reduction and health development. Indeed, three of the eight Millennium Development Goals address specific health issues: reducing mortality of children under age five, reducing maternal mortality, and reversing the spread of communicable diseases such as HIV/AIDS, malaria, and TB.⁷⁰ The other goals are also critical to health development. These goals address education,

66. Daniele Anastasion, *The Role of Health in a Security-Obsessed World*, SAIS REV. 175, 175-76 (2004).

67. Michael Marmot, *Social Determinants of Health Inequalities*, 365 LANCET 1099, 1101 (2005).

68. Ronald Labonte & Ted Schrecker, *Foreign Policy Matters: A Normative View of the G8 and Population Health*, 85 BULL. OF WHO 185, 185 (2007) (quoting F. Diderichsen et al., *The Social Basis of Disparities in Health*, in CHALLENGING INEQUITIES IN HEALTH: FROM ETHICS TO ACTION (M. Whitehead et al. eds., 2001).

69. Commission on Social Determinants of Health, http://www.who.int/social_determinants/en (last visited Oct. 4, 2007).

70. U.N. Millennium Development Goals, *supra* note 5.

gender equality, poverty reduction, and global partnerships.⁷¹ The U.N. has recognized these goals and the security concerns created by the social determinants of health. The security of nation states now depends more than ever on shared responsibilities, international cooperation, and improved accountability of all stakeholders, including attention by these stakeholders to the underlying determinants of health across sectors.⁷²

V. FOREIGN POLICY OPTIONS IN THE NEW ERA OF GLOBAL HEALTH GOVERNANCE

Given the rise in importance of global health, several important countries now include health as a key element of foreign policy.⁷³ Global health is rooted in national security concerns, as discussed above, and is rooted also in the increasing global concern for social justice and equity. Hence, a new field of health diplomacy is emerging. This new field of diplomacy is based more on altruism, human rights, and human security than concerns for the preservation of commerce, mobility, and power traditionally engaged through foreign policy.⁷⁴

There are several examples of health as foreign policy worthy of discussion. In the United Kingdom, the central government's Department of Health is developing a government-wide strategy to support global health.⁷⁵ The strategy will bring the U.K.'s foreign policy leadership, international development agency, and trade and investment policies to bear directly on global health. This initiative follows on the human rights agreements that the United Kingdom has signed.⁷⁶ It covers the availability of health care, health promotion

71. *Id.*

72. *A More Secure World*, *supra* note 1, ¶ 24.

73. Rebecca Katz & Daniel A. Singer, *Health and Security in Foreign Policy*, 85 BULL. OF WHO 233, 233-34 (2007). These countries include those which are G8 members: the United States, Canada, France, Germany, Italy, Japan, Russia, and the United Kingdom.

74. Mary Robinson, *The Value of a Human Rights Perspective in Health and Foreign Policy*, 85 BULL. OF WHO 241, 241-42 (2007).

75. Liam Donaldson & Nicholas Banatvala, *Health is Global: Proposals for a U.K. Government-wide Strategy*, 369 LANCET 857, 857 (2007).

76. *Id.* at 859.

and protection, safe water, adequate sanitation, and occupational and environmental concerns germane to health. It also recognizes the need to engage across multiple sectors of the U.K. government to respond to persistent and emerging global health threats, both to the United Kingdom and globally.⁷⁷

Switzerland proposed an agreement among its Federal Councilors (cabinet) to assure policy coherence among multiple administrative services active in global health.⁷⁸ This mapping of global health across government sectors established new mechanisms of coordination for a national global health strategy. This agreement includes domestic strategies relevant to international agreements and cooperation, international assistance on development, and policy activities in other relevant sectors (such as trade).⁷⁹ Brazil has involved its diplomats, trade negotiators, and health ministry in purposeful ways as national entities to support global health strategies.⁸⁰ Most notably, Brazil's national HIV/AIDS policy required actions at the 2001 WTO conference in Doha, Qatar to assure that health was the primary concern in discussions of pharmaceutical intellectual property rights.⁸¹ Further, Brazilian diplomats led the FCTC negotiation process, involving cross-governmental policy consistence to be able to sign and support this health treaty.⁸²

The European Union has increasingly asserted that the health of its people requires new processes and channels to engage all elements of society in the response to global health needs. European Foundations Centre has created the European Partnership for Global Health to raise awareness and utilize the bridge between governments provided by the EU structure.⁸³ Global health will likely now become

77. *Id.* at 857-61.

78. Ilona Kickbusch et al., *Global Health Diplomacy: The Need for New Perspectives, Strategic Approaches and Skills in Global Health*, 85 BULL. OF WHO 230 (2007).

79. *Id.*

80. *Id.*

81. *Id.*

82. *Id.*

83. EUROPEAN PERSPECTIVES ON GLOBAL HEALTH: A POLICY GLOSSARY 5 (Ilona Kickbusch & Graham Lister eds., 2006).

a policy priority for the EU, with a European approach to governance and health equity.⁸⁴

In March 2007, the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand issued a joint statement to broaden the scope of foreign policy to recognize health as one of the most important, but often neglected, policy issues.⁸⁵ They committed to an “Agenda for Action” involving collective approaches and emphasizing commitment to health and development as prerequisites to global security.⁸⁶ Collaborative actions included: using health as a defining lens for foreign policy, developing a “roadmap” in preparation for large-scale disasters and emergencies, strengthening the U.N. agencies to coordinate approaches to global health security, and identifying gaps in surveillance, outbreak investigation, and disease control.⁸⁷

Finally, the United States may now have opportunities to support health as a major component of foreign policy. Beginning with the President’s Emergency Plan for AIDS Relief (PEPFAR) in 2003,⁸⁸ substantial funds were devoted to international cooperation on HIV/AIDS. These started with a \$15 billion, five-year commitment, tied to several political objectives, now expanding to a proposed \$30 billion overall commitment.⁸⁹ Legislation has been proposed to carve out of this significant funding source for an innovative program to support global health diplomacy. The legislation follows on the heels of *Healers Abroad: Americans Responding to the Human Resource Crisis in HIV/AIDS (Healers Abroad)*, a report issued by the Institute of Medicine that called for the establishment of a Global Health Corps to help with manpower shortages, training needs, and responses to HIV/AIDS, TB, and malaria.⁹⁰ This health corps would serve as an important outlet for global engagement by U.S. health professionals,

84. *Id.* at 10.

85. Foreign Policy Taking Up the Challenges of Global Health: Agenda for Action, <http://www.norvege.no/policy/peace/peace/helse+og+utenrikspolitikkk++Agenda+for+Action.htm> (last visited Nov. 29, 2007).

86. *Id.*

87. *Id.*

88. President’s Emergency Plan for AIDS Relief, <http://www.pepfar.gov>.

89. HEALERS ABROAD: AMERICANS RESPONDING TO THE HUMAN RESOURCE CRISIS IN HIV/AIDS 19 (Bd. on Int’l Health, Inst. of Med. 2005).

90. *Id.* at 20.

initially focusing on target countries and diseases mandated by PEPFAR, but expanding in scope to support international collaboration and global service.⁹¹ Given the extensive negative feelings about recent U.S. foreign policies in the Middle East and elsewhere, a positive program of global health engagement might provide an opportunity for the United States to support true international cooperation and provide leadership. The human resources are needed, but what is needed more is an outlet for public diplomacy by health professionals in U.S. foreign policy.

VI. CONCLUSION

Global health has gained significant momentum through an expanded roster of partners, funding sources, and policy developments. Along with the disease challenges of globalization, this momentum has created new opportunities and challenges for governance structures. What is clear is that the sovereign state cannot protect the health and security of its domestic population without engaging globally and collaborating with other state entities, multinational organizations, the private sector, and non-governmental health groups. Health is a cross-cutting issue in foreign policy. Governments increasingly recognize they must prioritize health as a source of international security and develop coherent policies at the international as well as the national level. The twenty-first century is unfolding with health at the forefront of the U.N.'s global concerns, and, we may hope for critical new advances in global cooperation in health and development that will support a more cohesive and peaceful global community.

91. Fitzhugh Mullan, *Responding to the Global HIV/AIDS Crisis: A Peace Corps for Health*, 297 J. AM. MED. ASS'N 744, 744 (2007).