Addressing Global Health Governance Challenges through a New Mechanism: The Proposal for a Committee C of the World Health Assembly

Ilona Kickbusch, Wolfgang Hein, and Gaudenz Silberschmidt

Introduction

In January 2010 the Director General of the World Health Organization (WHO) called for an "informal consultation on the future of financing for WHO" and in her opening remarks expressed the need to make the WHO fit for purpose given the unique health challenges of the 21st century.[1]

Margaret Chan referred to the constitutional role that WHO has to "act as the directing and co-ordinating authority on international health work" and stated clearly that global health leadership today and for the future must be earned through strategic and selective engagement. She said, "WHO can no longer aim to direct and coordinate all of the activities and policies in multiple sectors that influence public health today." This is a clear challenge that she has put to the global health community in recognition that WHO's role must be clarified in the face of major change.

There has been much discussion about improving global health governance and even calls for a new global health architecture.[2] Some authors continue to see WHO in the center of such a new configuration. Others see it as one organization amongst many others, and some consider it outdated. But the role of the organization can only be determined if there is greater clarity about the various domains of global health and its role in relation to them. One problem is that in debating the need for better governance and coordination in global health, many analysts focus exclusively on one part of the global health governance picture: the complex landscape of health in development. It is in this arena of global health that the actors have increased exponentially and visibly — disease by disease — over the last 20 years, and it is here that many new governance mechanisms and institutions were developed. The explosion of actors and activities in this domain of global health is due in particular to a widening resource base for mainly vertical health activities. Funding for global health initiatives has quadrupled in less than two decades to almost $22 billion, boosted in particular by United States public funding (PEPFAR), corporate donations, and giving from private foundations such as the Bill & Melinda Gates Foundation.[3]

But the realm of global health governance is much broader. Governance according to Stephen Krasner[4]

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includes "implicit or explicit principles, norms, rules and decision making procedures" according to which the international actors operate. Today these clearly emerge in a more complex manner than when the World Health Organization was the only health game in town. As the environment gets more complex, a new need for coherence and coordination in global health governance is recognized.[5] In the crowded landscape this is clearly an empty space — a governance void — which WHO should fill. WHO's responsibilities lie exactly — in concordance with its constitution — in the establishment of principles, norms, and rules according to which the wide range of global health actors should shape their actions, be they member states, donors, foundations, or public-private partnerships. The critical difference at the beginning of the 21st century lies in the decision making procedures of how these principles, norms, and rules are developed. They call not only for the involvement of the broad range of global health actors but also for increased transparency and accountability.

As the environment gets more complex, a new need for coherence and coordination in global health governance is recognized. In the crowded landscape this is clearly an empty space — a governance void — which WHO should fill.

Three strategic pathways emerge for the organization, all of which imply a new relationship with member states, other international bodies and organizations, civil society, and the private sector:

1. WHO needs to provide mechanisms and instruments which link the new global health actors to the system of multilateral intergovernmental institutions. This has become necessary because the growth of actors and resources in global health is beginning to show negative effects on the global health system as a whole by creating fragmentation and risky imbalances. Quite simply put, the "invisible hand" no longer ensures that the high number of actors and approaches helps achieve the best results — coherence, transparency, and accountability are called for.
2. WHO needs to engage in new ways with the many non-health actors that can influence health both positively and negatively. Strategies on obesity, alcohol, and climate change all touch on a broad mix of policy arenas, sectors and multiple public and private actors. Health is part of geopolitics, security, trade, and foreign policy. The recent resolution[6] in relation to the report of the Commission on the Social Determinants of Health for example "requests the Director-General to work closely with partner agencies in the multilateral system on appropriate measures that address the social determinants of health and promote policy coherence in order to minimize health inequities; and to advocate for this topic to be high on global development and research agendas." The organization clearly lacks formal institutionalized means of dealing with other sectors.
3. WHO needs to be better able to fully perform its coordination function in relation to the development on legal instruments such as the Framework Convention of Tobacco Control[7] and the revised International Health Regulations[8] that were adopted in 2003 and 2005 respectively and have since come into force. It needs to build on these experiences to explore other instruments which address trans-boundary health challenges and the governance of global public goods for health. This means allowing for the involvement of actors who will be contributing to the development of these international instruments. This could include developing rules of the game for health donors.

Our proposal to the WHO — which we have named Committee C — tries to respond to this need for new decision-making procedures, as well as transparency and accountability, and places the proposed mechanism *within* the World Health Assembly (WHA).[9] We suggest that the WHO use the unique convening power of the WHA as well as its rules of procedure to construct more effective relationships with the broad array of non-state and state actors that have so far not been involved in a systematic way, in particular from sectors other than health. Our focus is not the coordination of development donors for health — which we do not think of as WHO's role — but the challenge of how their accountability to the global health community can be increased in the context of other normative and strategic dimensions of global health governance. This will make WHO's work more complex but adjust its governance mechanisms to the new landscape and new priorities of global health action. Such a move will require the organization and its member

states to adopt new concepts, skills, instruments, and outlooks.[10]

We maintain that at this point in time there is a unique window of opportunity to move forward. We describe Committee C below after reflecting on the development of global health governance in the last decades. We are under no illusion that one single mechanism will resolve the complex challenge outlined, but we believe there is every reason for WHO to fill a governance void and to attempt governance innovation.

1948 Legitimacy: A Directing and Coordinating Authority on International Health Work Is Established

It was a joint declaration by Brazil and China at the San Francisco Conference 1945 which called for the establishment of an international health organization. It stated that the health of all peoples was to be seen as fundamental to the achievement of peace and security. This broad view on health was enshrined in the preamble of the constitution of the organization. Membership is open to all sovereign nation states of the world — not only U.N. member states — which is why the broadest possible title for the organization was selected: the World Health Organization. It was argued that health is a fundamental right of human beings and that international cooperation to the fullest possible extent is necessary for achieving that purpose. To restrict membership would contradict the preamble.[11] Consequently, the WHO is the only health organization in which all nations states are members and have equal representation: one country, one vote. This makes its legitimacy different from all other health organizations and constitutes its convening power.

Formal-Legal Legitimacy

Legitimacy as a concept can apply to many kinds of organizations and authority, and there are different sources of legitimacy that various actors can refer to.[12] Of the global health actors only the WHO has the *formal-legal legitimacy* for the collective action of all states — it includes all nation states, small and large, weak and strong, rich and poor. This gives it the legitimacy within international law provided by the sovereign equality of members (States) who consent to certain rules of diplomacy and procedure, consent to legal norms, and an ongoing participation in international regimes. In principle the members commit to upholding certain standards of behavior, and are required to justify their conduct in light of those standards. WHO is the only organization in global health that is mandated by its constitution to "act as the directing and coordinating authority on international health work."[13]

Important Functions of WHO as Defined in Chapter 2 of Its Constitution

(a) to act as the directing and co-ordinating authority on international health work;

(b) to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate;

(c) to assist Governments, upon request, in strengthening health services;

(g) to stimulate and advance work to eradicate epidemic, endemic and other diseases;

(i) to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene;

(j) to promote co-operation among scientific and professional groups which contribute to the advancement of health;

(k) to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective;

(o) to promote improved standards of teaching and training in the health, medical and related professions;

(r) to assist in developing an informed public opinion among all peoples on matters of health;

(t) to standardize diagnostic procedures as necessary;

(u) to develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products;

Since its creation, the legitimacy of the United Nations (U.N.) system is based on the respect of the sovereignty of each member state, with a few and very limited exceptions concerning peace-keeping by the U.N. Security Council. The WHO draws its legitimacy from this base, and member states remain responsible for the health of their people. A central innovation in the WHO Constitution was allowing the organization to develop legally binding conventions or agree-

ments and regulations "with respect to any matter within the competence of the Organization" (Articles 19-22), a function that the organization began to use actively only in the early years of the 21st century. It has become clear that the development of internationally binding rules and norms needs the authority and responsibility of an intergovernmental organization backed by the legitimacy of governments. After the successful experiences with the Framework Convention on Tobacco Control (FCTC) and the new International Health Regulations (IHR), the role of binding international law in health has become better understood. Joint vulnerability has allowed for governance innovation: for example, the revised International Health Regulations have in 2005 been able to introduce elements of action for the organization that transcend the non-interference principle and require full transparency from member states. This leads to new challenges of coordination and potential areas of conflict between member states and the organization and to the discussion of strengthening the instrument of the IHR through additional components.[14]

Other Forms of Legitimacy

As the United Nations technical agency for health, the WHO has been able to benefit from another form of legitimacy based on knowledge, expertise, and evidence. Meanwhile a wide range of expert organizations in the global arena are also able to provide this type of legitimacy — but they do not have the link to formal legal legitimacy, which allows the WHO to be a normative and standard-setting organization. *Moral standing* is another critical source of legitimacy, which is very important particularly for civil society organizations in global health particularly in relation to the human rights agenda. But it has always been an absolutely essential source of legitimacy for the WHO. The organization is expected to live up to the universal values on which the United Nations system is founded through promoting human rights and access to primary health care, addressing health inequalities and advocating for health in the face of adversity, for example against the global tobacco industry. It is also expected to act as a trusted neutral broker. Any hint of lack of independence — as contended for example in the recent debate on H1N1 — can have serious repercussions for the work of the organization.[15]

WHO over the years has been challenged — for many different reasons — in relation to different forms of legitimacy. The criticism that was most damaging for the organization in the 1990s relates to results-based legitimacy. WHO was increasingly seen as not responding adequately to global health problems; its outputs were judged unsatisfactory by a number of important actors and even its moral standing was questioned in relation to its leadership. In this period the new organizations based on results based legitimacy gained significant strength, made possible by the significant resource flow into global health and a new paradigm of market multilateralism.[16] The entry of many new actors in the global health arena has led to a dispersal of legitimacy and new organizations can lay claim to legitimacy based on results, expertise, and moral standing. Any attempt to coordinate actors in the global health arena must balance actors with very different forms of legitimacy. It seems obvious that the organization's attempting any such coordination would need to be strong on a number of dimensions of legitimacy; otherwise, it would not have the authority to act.

As Dr. Chan stated,[17] leadership must be earned — an institution is perceived as legitimate not only if it is constitutionally the most appropriate one for the issue at stake, but approval for that institution needs to be general among those who will be subject to its authority. We believe that the WHO through its unique combination of formal-legal legitimacy, combined with expertise based legitimacy and moral standing, still is the organization that can demonstrate legitimacy for coordination of global health more than others. WHO has responded in many ways to the increasing diversity of global health actors and already become host to a multitude of partnerships and alliances. In our view results-based legitimacy in relation to the WHO must not be sought in areas for which it is not the appropriate organization to act — i.e., implementation of health programmes in developing countries — but in the results linked to establishing principles, norms, and rules such as the adoption of two major global health treaties, the significant work done in standard setting, advice to countries, the development of innovative health strategies, the eradication of major diseases such as small pox and its results in responding to global outbreaks, etc. It is in these areas of work that WHO must be judged in terms of results, and a discussion needs to be conducted whether it has the means at its disposal to fulfil these constitutional functions adequately, particularly in the domain of "health security" and with regard to global public goods for health.

1989: Dispersed Legitimacy and the Expansion of Actors

It is important to realize the extent to which the constitution of the World Health Organization represents a major governance innovation — from the start its task was to reach out beyond the member states only. When at its inception in 1948 the WHO was entrusted

with the task of acting as "the directing and co-ordinating authority on international health work," this was understood as establishing and maintaining effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups, and other such organizations that may be deemed appropriate by the Constitution of the World Health Organization, Chapters 2 a. and b.

Chapter XVI of the WHO constitution (articles 69-72) calls not only for close cooperation with U.N. and specialized agencies, it goes further and authorizes the organization to make arrangements for consultations and co-operation with non-governmental international organizations, and even, subject to the governments' consent, with national organizations. "This latter clause is commonly regarded as being potentially among the most fruitful innovations introduced by post-second world war international legislation."[18] This clause built on decades of experience with the extensive participation of non-state organizations in national and international health work: Medical Associations, the Red Cross, foundations, and above all missionary and philanthropic activities had been active in international health for at least a century. The role of the Rockefeller Foundation had been particularly important: for example during the 1920s, it financed between a third and half of the League of Nations Health Office budget.[19] The parallels to the dominant position of the Bill & Melinda Gates Foundation today — who in 2007 spent roughly as much on global health as WHO's budget for that year — are obvious.[20]

Existing health organizations (such as the Pan American Sanitary Bureau) were integrated into the WHO as regional offices to ensure coordination, and new offices at regional and country level were created to ensure a worldwide presence. Until the 1970s the WHO remained unchallenged as the leading international organization in health. Financial support by non-state actors played a negligible role, and a small number of NGOs had a well-defined role as observers with a rather limited impact on international health affairs. Two factors led to major change: the rise of development assistance and the rivalry between different models of providing health care in developing countries, which was symbolized through the conflict between comprehensive primary health care and selective primary health care.[21] Together these began to challenge WHO's hegemony and created competition among organizations that was detrimental to health. For example, UNICEF's move to provide large-scale immunization programs and the entry of the World Bank into health care financing both undermined efforts to establish sustainable health systems in developing countries. This was followed by the rise of the civil society organizations, initially organized around women's health, HIV/AIDS and human rights and health, but expanding into ever more areas of action and advocacy.

The processes of globalization catapulted health to a more prominent political place on the global agenda and many new actors entered the global health arena, initially in relation to the development agenda. Together they formed collective action of a new type, moving beyond the nation state. In particular they created *hybrid alliances or organizations* — frequently called public private partnerships — in pursuit of specific health goals. A fundamental change in governance began to take shape — market multilateralism — and many networks and alliances have brought nation states, civil society organizations, private foundations, pharmaceutical corporations, and international organizations together to address development challenges. They now have a significant impact on setting agendas, shaping global health policies and implementing programs. Their sheer number is staggering: a 2007 estimate of AIDS-related NGOs alone counted more than 60,000.[22] More than 200 public-private partnerships are operating in fields such as developing new medicines for neglected diseases, improving access to medical treatment or pooling resources for specific goals. While they have gained increasing power they "suffer from problems of legitimacy and *accountability,* in part, due to a lack of *transparency* and, in part, due to the nature of their membership, which is dominated by developed countries."[23]

Beyond the development agenda a wide range of factors have contributed to the increasing consideration paid to global health by different actors:

- **Inequality of access** to health around the world has gained more attention and has become a major issue of human rights and social justice.
- **Health threats** such as influenza, SARS, or avian flu threaten every country and the global community as a whole due to the rapid spread based on global travel and mobility. Their impact frequently has very serious economic repercussions.
- The **globalization of lifestyles** has led to common chronic disease challenges such as diabetes and is linked to the impact of global industries, including those of tobacco, alcohol, and food.
- The health sector is a **critical sector for stability** in many countries, and health care financing is a key political issue in all countries. The mobility of patients and health care professionals is a global issue

- Health is **one of the largest industries worldwide**, critical issues — for example, intellectual property and trade in goods and services — have major economic consequences for companies and countries, and major consequences in terms of access for poor people and countries.

Consequently, global health has become a concern and at times a precondition for quite a number of policy fields like economic policy, foreign policy, geopolitics, security policy, investment and marketing strategies, and human rights. This is part of the reason why there are so many different interpretations and usages of the term "global health."[24] People tend to apply the reference frame and interest from which they themselves approach the global health agenda. This diversity in the way in which global health is understood leads to many misunderstandings and illuminates that some of the problems of coherence and coordination are due not only to the lack of institutional mechanisms or an unwillingness to cooperate but also to very different mindsets of the actors involved.[25]

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2010: Need for Coherence and Coordination

WHO was initially ill prepared to respond strategically to the new importance health gained first in the global development agenda and later in the security agenda. It was in the arena of development assistance that WHO has been most radically challenged, since it was not set up to deliver interventions at country level. At the same time (true to its mandate on setting norms and standards) one of the most quoted reference points in the development debate — the report of the Commission on Macroeconomics and Health[26] — was initiated by the organization. It was in the arena of health security — **the arena close to its constitutional functions** — that WHO regained much of its strength through the rapid action in relation to SARS and the adoption of the revised International Health Regulations. Many health NGOs also re-established trust in the WHO in the course of the negotiations of the Framework Convention on Tobacco Control and the Report of the Commission on Social Determinants of Health.[27]

The projected "weakness" of the WHO became most palpable as HIV/AIDS spread around the globe at astonishing speed in the 1990s while WHO was engaged in internal conflicts, which followed after a period of strong and clear moral leadership. It was reinforced when WHO was not considered active enough in relation to the "health goals" of the Millennium Development Goals, and through the presence of new donors with significant resources, first and foremost the Bill & Melinda Gates Foundation. Furthermore, it did not help that many of the new players expected the wrong things from the WHO. Many did not — or did not want to — understand WHO's unique governance function which lies in establishing principles, norms, and rules, i.e., creating legal instruments, developing global strategies that provide direction, setting norms and standards, and coordinating global efforts in eradication and disease control where appropriate. The critique of many well-meaning global health players of the WHO inadvertently played into the hands of those who wanted to see the organization's legal and normative functions weakened, be it some member states or some trans-national companies.

Many of the new alliances and networks have focused on *specific health problems* through result-oriented strategies and have been able to act with speed, flexibility, and innovation. For many different reasons, many of these actors initially bypassed the WHO.

New issue-based organizations such as the GFATM and GAVI were created, introducing new governing structures, which included both state and non-state actors including the private sector. It was implied — and sometimes heralded — that such public-private governance structures had higher legitimacy than the purely state-based legitimacy of the WHO. It is quite clear that in the period of unilateralism there was no interest by the hegemonic U.S.A. to strengthen a U.N.-based organization. Thus, in the 1990s WHO was pushed into the frame of a development organization and began to compete for funding of programs with the many other actors; as a result, for a period it lost much of its influence and strategic purpose.

Overall the many new health initiatives and actors have put health high on the global development agenda and had an important effect on priority setting. More recently though many analyses have shown that they have also achieved the following:

- reinforced the verticalization of approaches to resolve global health challenges;
- bred competition among actors on the ground and in the international arena;
- created expensive transaction costs for donors having to deal with so many organizations and initiatives;
- created a burden for ministries of health in recipient countries having to work with and report to a multitude of partners;
- led to fragmented health programmes that compete for limited numbers of trained staff at the country level, but also internationally; and
- weakened support to health systems.

As a consequence, the great optimism that initially accompanied these developments has gradually been tempered. A consensus is emerging that their success was achieved at the cost of fragmentation, created ineffective parallel activities, neglected the need to strengthen health systems, and increased problems of transparency and accountability at all levels of governance. But the reproach that is probably most serious for a movement that has *results* as its major claim to legitimacy is that not only are the counterproductive system effects being debated, but their overall health impact is also being questioned.[28] Many actors in the global health arena have begun to recognize that the institutional proliferation and complexity in global health requires additional coherence and coordination mechanisms in order to make an effective use of available resources.

Global Development Coordination

The coordination efforts that have been established center on problems related to development cooperation, in particular the Paris Declaration on Aid Effectiveness and subsequently the Accra Declaration.[29] The most important initiative in this context is the International Health Partnership+ which aims at coordinating the activities of all relevant donor organizations.[30] The paradigmatic character of "health" as a problem of "aid effectiveness" has been recognized by the OECD and the World Bank (the leading organizations of the aid effectiveness process) as a "tracer sector" to be used as a "litmus test for broader aid effectiveness efforts."[31] The Paris Declaration and Accra Agenda for Action on enhanced Aid Effectiveness have agreed on a set of principles:

- *Ownership* — developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.
- *Alignment* — donor countries align behind these objectives and use local systems.
- *Harmonization* — donor countries coordinate, simplify procedures and share information to avoid duplication.
- *Results* — developing countries and donors shift focus to development results and results get measured.
- *Mutual Accountability* — donors and partners are accountable for development results.
- Predictability — donors will provide information 3-5 years in advance of their plan to aid partner countries.
- *Country Systems* — partner country systems will be used to deliver aid as the first option, rather than donor systems.
- *Conditionality* — donors will switch from reliance on prescriptive conditions about how and when aid money is spent to conditions based on the developing country's own development objectives.
- *Untying* — donors will relax restrictions that prevent developing countries from buying the goods and services they need from whomever and wherever they can get the best quality at the lowest price.

With regard to donor-financed health programs, these principles clearly hold and are of high relevance. But additional accountability of a wider nature is also required: for example, it needs a debate why donor agencies do not act in accordance with major policy principles of the World Health Organization or with the World Health Assembly resolutions in implement

Box 4: Public Goods and Global Public Goods

A public good is defined according to two characteristics: rivalry and exclusivity. A public good is a good which is non-rivalling in consumption and the access to which cannot be excluded.

If one person's consumption of a good completely precludes anyone else's ability to enjoy that good, then it is strictly private. For instance, one person's car cannot be simultaneously driven by someone else. But it is not always so black and white. A bus system has public characteristics in that everyone with a pass has access to that mode of transportation. And yet, there is some degree of rivalry because there are only so many seats, and of course, someone who cannot afford a bus ticket will be excluded from the system entirely. This framework is important for determining how a good ought to be produced. A purely private good will be handled by the market, whereas varying degrees of publicness demand state intervention to ensure sufficient production for equitable consumption. The public goods concept has traditionally been understood in terms of national economy and government, for which a single policy-making body has control over the publicness of a good's production and the balancing of positive and negative externalities.

In a global economy challenges arise because nationally produced goods have impacts across borders, which means that consumption may be completely disconnected from the decision-making process that creates that good. Therefore, the international community has increasingly recognized that production and management of certain goods (i.e., clean air) must be managed at the supranational level both to prevent free-riding where one state pays for the good but others benefit, and to make sure that all those impacted by the goods production can participate in its provision in some way.[33]

ing their health strategies. We believe that this kind of debate needs to take place under the auspices of the World Health Assembly with the involvement of the many actors concerned in order to establish principles, norms, and rules for development action in health. Possibly this could lead to the type of Framework Convention on Global Health that has been proposed by Lawrence Gostin.[32]

Global Public Goods Coordination

But the global health governance responsibility of the WHO does not lie foremost in the donor-recipient-relationships. It is to a large degree concerned with the provision of global public goods, e.g., securing access to vaccines or succeeding to eradicate a virus, monitoring the spread of an infectious disease and enforcing travel restrictions, implementing measures of tobacco control, supporting the diagnostic capacity in remote parts of the world, or promoting systems of research for neglected diseases — all of which have benefits for the entire global community but require the investment of a large spectrum of actors whose primary objectives may or may not be related to health outcomes. In some cases — in particular with regard to health-related knowledge closely linked to the production of medicines — the question of publicness is closely entwined with aspects of health equity, the relationship between intellectual property rights, prices of medicines and access to them. It is here in the area of establishing principles, norms, and rules for global public goods for health that we see the greatest opportunities for a new kind of debate at the World Health Assembly with the involvement of the many actors concerned, particularly those beyond the health sector.

From International to Global Health Governance

Intergovernmental organizations have been established whenever governments recognized a common interest to create a minimum of continuous coordinative capacity at the international level. This clearly happened in 1948 when the WHO was established. These organizations are legitimized by the consent of participating sovereign states, as their governing bodies are representative of national governments. However, globalization has put this system of intergovernmental organization under stress. On the one hand, both the slowness of decision making within many intergovernmental organizations and the problems of representation are criticized. On the other hand, the mounting interconnectivity and the increase of trans-national social relations imply a growing need for rules of the game and increase the importance of international agreements and norms, which are developed in the context of these very institutions.[34]

WHO was set up as an intergovernmental organization (IGO) with three organs: the World Health Assembly, the Executive Board, and the Secretariat. The Executive Board was originally conceived as a body of experts technically qualified in the field of health. Its members were to "exercise power delegated to them by the Conference on behalf of the whole Conference, and not as representatives of their respective governments." The Executive Board then presented its deliberations to the representatives of the member states at the WHA — a unique construct of mixing professional and political decision-making power. This was then changed (in the late 1990s) so that members of the Executive Board now represent their countries,

reflecting the increased politicization of the organization. Of course, WHO negotiations have always been subject to a wide range of interests, to coalition and bloc building processes among nations as well as to periodic attempts to curtail the autonomy of the organization by powerful states — at times the organization has come close to paralysis. The negotiations can be tedious and lacking in transparency, and they are not always as focused on health as one would wish them to be. The tradition of working by consensus is felt by many to be frustrating and outdated.

Such problems common to all international organizations have certainly played a role in stimulating new actors to move into the health arena and to search for new institutional arrangements that would work "better" than the WHO. In health the tangible outcome — often reflected in life or death — creates a pressure and dynamic of its own, not as present in other areas of global policy. But it is also the nation states themselves that have weakened their organization, in particular through the ceiling put on the assessed contributions since the so-called United Nations Reform Act (Helms-Biden Act), a 1999 U.S. law that set a number of conditions for reform of the U.N. system before the U.S. would release its total amount of arrears in payment to the U.N. This introduced the principle of zero nominal growth into the WHO budget process and forced the organization to be dependent on extra budgetary resources, a relationship that is now at about 20:80 in favour of extra budgetary resources. This becomes a problem when the WHO is forced to compete for funding with others bodies, NGOs and even countries because the "steady shift to a competitive model of funding runs the risks of undermining their crucial role as trusted neutral brokers between the scientific and the technical communities on the one hand, and governments of developing countries on the other."[35] It can also undermine WHO's strength as an organization that establishes international law and sets norms and standards — a function that should be largely supported by reliable regular budgetary resources.

This lack of resources for global policy development also becomes relevant in view of the growing interdependence between various policy fields in inter- and trans-national relations in global health. Health increasingly is part of the deliberations of organizations not dedicated to health — because their actions have a high health impact.[36] Negotiations on trade, food, and climate change are obvious examples, and WHO both needs to be able to have a higher involvement and bring those debates into the organization, both of which are resource intensive. From its inception the WHO had close cooperation with the United Nations and ECOSOC, and negotiated agreements with many intergovernmental organizations such as the following: UNICEF in the field of child health; FAO concerning food safety; the International Labour Organization concerning occupational safety and the health of workers; UNESCO regarding scientific documentation; and the International Civil Aviation Organization. One of the first tasks of the Executive Board was to appoint the WHO members of the UNICEF/WHO joint committee on Health Policy. But the list of organizations and policy arenas is ever expanding: new U.N. organizations for health have been created such as UNAIDS, other bodies such as the World Bank, WTO, WIPO, UNDP, and UNCTAD have become increasingly involved in health affairs because of the health impacts of their policies. In response WHO needs expertise in these areas to be able to contribute effectively in relation to these health impacts and consequences. Clearly there is an increasing interdependence in the norm-setting process (for example intellectual property and health) and an increase in joint operational activities of intergovernmental organizations. This has increased the expectations put on the WHO but not the resources available to do so.

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The recent period has also been characterized by a new geopolitical challenge to the existing system of intergovernmental institutions which will also have an impact on global health governance. Like other arenas of governance, the field of global health governance is subject to reconfigurations of power — it is always also a political undertaking, which allows new actors to mobilize discursive as well as financial resources to challenge the power of established actors.[37] The recent negotiations in December 2009 at the Climate Summit in Copenhagen have shown some of these new trends very clearly: a defining role by the

emerging economies, a final document negotiated at the highest level by a group of 30, and a refusal of the full Summit Assembly to approve the document.[38] In the wake of the summit, there was increasing criticism that while the need for collective action has become ever more urgent, the large U.N. Assemblies no longer seem capable of producing results based on consensus. Already there is a clear tendency of countries to use club models in addition to the processes of established international organizations — basically undemocratic institutions.[39] These can take many different forms:

- They can be at the level of heads of state — established first by industrialized countries (such as the G7/G8 meetings and a strengthened role of the OECD), now also increasingly by the emerging economies (IBSA).
- More recently the global power shift has led to the establishment of the G20 and the role of regional bodies like the European Union is increasing at the global governance level.
- New proposals have launched the term "minilateralism"[40] — an approach that should bring to the table the smallest possible number of actors with the largest possible impact on solving a particular problem.
- And finally there is the increasing alliance between middle powers and civil society actors as exemplified in the process for the International Court of Justice (ICC).

The challenge at present is how WHO and its governing bodies are positioned in this period of geopolitical transition in relation to such club models - raising issues of legitimacy and accountability, for example, in relation to the World Health Assembly. While one would, of course, want to see a strong health commitment from "high policy" bodies, the issue remains how that is influenced by and fed back into the coordinating authority for health.

Networked Global Health Governance: The New Diplomacy

This dynamic interaction of the many players in global health is usually captured by the concept of "governance." While a government "governs" by using its constitutional powers to pursue specific goals, the term "governance" rather looks at the interactive processes between different actors in the absence of a central authority which lead to a specific outcome. It has frequently been associated with "governance without government," a view that is increasingly challenged as the role of states in the global governance system is better understood. Indeed since the global financial crisis, the state has come back on the international scene very forcefully. The Commission on Global Governance (1996) has suggested a standard definition of global governance stating that "governance is the sum of many ways individuals and institutions, public and private, manage their common affairs. It is a continuing process through which conflicting or diverse interests may be accommodated and co-operative action taken. It includes formal institutions and regimes empowered to enforce compliance, as well as informal arrangements that people and institutions either have agreed to or perceive to be in their interest." [41]

We have already outlined that contemporary global health governance is characterized by a polycentric, distributed structure. It has become a complex web of state and non-state actors, and it is defined by the interplay of different institutional forms and actors at many different levels. There are new resources, new financing arrangements, new organizational structures, and new international agreements. There are new processes, highly flexible networks, partnerships, new interfaces, and a multitude of information systems, thus creating a more complex interface than in most other sectors of global action. Transnational corporations (TNCs), foundations, civil society organizations (CSOs), and various other forms of private associations are progressively forming the civic foundation of a global polity which makes its presence felt in many different ways in international organizations.[42] Thus, depending on the vantage point, one can see global health governance as a creative plurality, fragmentation, or anarchy of actors.

These actors defend their own interests, pursue advocacy positions, and exert political pressure from inside national polities as well as on the global level. They take sides in public conflicts, lobby, and use various media and the internet to spread their positions. They also offer resources (financial as well as expertise) from outside the state system for the achievement of public goals. Proactively, they associate with national as well as international state actors to form *hybrid alliances or organization*. Non-state actors can also play a significant role in developing transnational norms and play an important role in building and defending international law, e.g., in the field of human rights. This process which has been termed the "new diplomacy" is most clearly exemplified by the "Ottawa Process" which led to the treaty banning anti-personnel land mines and by the Rome Statute to establish the International Criminal Court.[43] In these cases such new forms of alliance building basically allowed the bypassing of many major governmental players opposed to the agreements.

Today, trans-national discourses on health — also magnified through the media and the internet — are very important in raising issues, setting agendas, and in particular, producing the discursive frames, in which problems are then debated in intergovernmental organizations and other international fora. The increasing density of trans-national communication creates a new dynamic and a dense web of exchange. Specific actors or institutions emerge as nodes of information and coordination and the interactions taking place may reshape the goals, perceptions, interests, and relationships of the various actors.[44] In global health this is exemplified by the Access to Medicines Campaign. One way to understand these interactions is to consider them as networked governance. Networked governance is a specific form of organization because it depends on governing nodes. A node must have some institutional form, even if temporary. It need not be a formally constituted or legally recognized entity, but it must have sufficient stability and structure to enable the mobilization of resources, mentalities, and technologies over time; many global movements have such nodes. Given the many players, networks, and alliances in global health (which all have their respective nodes), there is a need for a "superstructural node," which brings together representatives of different nodal organizations. Superstructural nodes are the command centers of networked governance.[45] They concentrate the members' resources and technologies for a common purpose but do not integrate the various networks into a common structure. This type of thinking is at the basis of our suggestion for a Committee C because we consider the World Health Assembly a "superstructural node" of networked global health governance.

The World Health Assembly as a "Superstructural Node": Committee C

There is now a growing recognition that a side lining and weakening of international organizations in global governance — in this case the World Health Organization — can prove counterproductive and may harm efforts to improve health around the world. This has brought the question of the WHO's role to "act as the directing and co-ordinating authority on international health work" back on the global health governance agenda. Can WHO be part of the solution to improve global health governance? Does it have instruments already at its disposal that could help fill the governance void described above? Can it adapt to networked governance?

The institutional proliferation and complexity in global health requires coordination mechanisms that are broadly accepted and work to the principle of networked governance. The World Health Assembly (WHA) already has a central position as a "superstructural node" in global health governance. It is now a unique meeting place of global health actors. Indeed global health governance — more than other arenas of global action — is particularly illustrative of a new relationship between state based entities and non-state entities. The World Health Assembly fully illustrates this:

- On the one hand the WHA ensures the interface between the delegates of its members (nation states) and the interface of the delegates with the representatives of many other global health actors. Quite independent from what is being discussed in the formal agenda of the Assembly the new "polylateral diplomacy"[46] is conducted throughout the WHA: formal and informal meetings take place, agreements are reached, deals are struck, NGOs exert influence, the private sector lobbies, receptions are organized. In short, key global health players participate in the Assembly during this period, even if they are not part of the formal meetings at the Palais des Nations.
- On the other hand, the formal processes of the World Health Assembly continue to guarantee a legitimate decision-making process that allows the interests of nations which are otherwise not powerfully represented in many of the networked global governance processes or the club models to express themselves and to contribute to a decision-making process which is defined first and foremost through its formal-legal legitimacy, but also carries other forms of legitimacy within it.

The challenge for the WHO is to provide an interface — the polylateral diplomacy venue — between these two types of nodal governance through the World Health Assembly.

The premise of our proposal is that the World Health Organization should be strengthened to fulfil its constitutional mandate. But it needs to develop new mechanisms to apply this mandate to the changed realities of the 21st century. Coordination in the 21st century means establishing coherence through hard and soft power, norms and networking, through transparency and accountability. We propose that the World Health Assembly — not the WHO secretariat — as the totality of member states and the prime governing body with formal-legal legitimacy within global health governance should be at the core of any such mechanism. We are convinced that — in line with WHO's

constitution — the overall normative and strategic coordination of global health action should be the task of the WHA and thereby be approved by the delegations representing all governments of the world, but a broader input base into the decision making process is clearly necessary. We are proposing a mechanism that does not need a change of the WHO constitution and could be implemented rapidly if the political will were mobilized.

Through Article 2 of its constitution WHO has a constitutional mandate to address global health issues in general and not only the governance of WHO itself. Until now, the global coordinating function of WHO has not been formally recognized by many of the new partners; indeed, several maintain that they have come into existence precisely because the WHO system does not work well enough to meet global health challenges. However, few of these partners can work without a link with WHO, particularly those at the country level. The WHA meets once a year and is attended by delegations from all of WHO's 193 member states; it is the G193. The WHA mostly takes its decisions by debating and adopting resolutions (which are non-binding in nature — i.e., soft law), but it also has the authority to adopt binding international health law, such as the Framework Convention on Tobacco Control and the International Health Regulations.

All member states, no matter how small or poor, are represented at the WHA. It is the poorest that are most effected by the lack of coherence and coordination. This means that they would have a voice in the Committee C debates. All other new mechanisms for coordination at present — like H8 or IHP or the G20 — are club models which exclude them. The clubs are important but they are not transparent and membership is exclusive. Not only do NGOs not have enough voice in the global governance process, the same also applies to a range of poor countries in the face of donor pressure. We believe that having to negotiate in public will over time make a difference. Major global health actors have to be challenged in a legitimate forum as to the systemic impact or the unintended consequences of their actions.

Currently, the formal work of the WHA is focused on determining the policies of WHO itself and on making recommendations for member states. Currently the WHA prepares its resolutions and the decisions to be taken by its plenary in two main committees: Committee A dealing with programme matters, and Committee B with budget and managerial concerns. The mechanism we propose is to consider the establishment of a Committee C of the WHA which deals with coherence, partnership, and coordination. We have built our proposal for a Committee C on article 18 of WHO's constitution where there are at least three provisions that allow an entry point for establishing a mechanism to ensure more transparency and debate between global health players:

- "to establish such committees as may be considered necessary for the work of the Organization";
- "to instruct the Board and the Director-General to bring to the attention of Members and of international organizations, governmental or non-governmental, any matter with regard to, health which the Health Assembly may consider appropriate"; and
- "to invite any organization, international or national, governmental or non-governmental, which has responsibilities related to those of the Organization, to appoint representatives to participate, without right of vote, in its meetings or in those of the committees and conferences convened under its authority, on conditions prescribed by the Health Assembly; but in the case of national organizations, invitations shall be issued only with the consent of the government concerned."

Of course coordination in global health governance is not a goal in itself, broader levels of cooperation aim to provide more fairness, more security and more effectiveness through increased coherence in global health policy and programmes. The starting point is shared interest rather than coercion in achieving a common goal. Critical mechanisms are dialogue, transparency, and accountability within a context of nodal governance. To better understand the function of Committee C it is useful to distinguish operative, normative, or strategic mechanisms of coordination.

- *Operative mechanisms* come into existence mainly for the purpose of implementation, with a focus on activities dealing with procurement, distribution and delivery on the ground, but also in the coordination of concrete research and planning processes.
- *Normative coordination* seeks to align the value systems and standards of multiple actors and build consensus among sometimes vastly different stakeholders in health initiatives.
- *Strategic (or programmatic) coordination* applies to mechanisms which help to develop a specific strategy to reach a broader goal in global health, aiming at developing a programme which is acceptable to a larger group of different actors or to rally support behind a rather broadly defined strategy. This is basically a political task,

frequently performed by intergovernmental organizations, but also by broader policy networks. It links normative and operative aspects, understanding that a particularly underlying agenda must be compatible with the normative frameworks of actors involved and links that to both standard-setting and implementation. It implies an acceptance of the legitimacy of the coordination institution or network.

Committee C clearly deals with the latter two forms of coordination: normative and strategic. First and foremost there must be agreement on the normative framework upon which global health governance can be built. Committee C would provide the opportunity for global health players and organizations to present their plans and achievements to the delegates of the WHA, to each other and the non-governmental organizations in official relations with WHO. In doing so it would create a new type of accountability and transparency in global health. It would also provide an opportunity to address coordination and common concerns of different players in global health.

A Committee C would need rules of procedure that give sufficient space to these players while fully respecting the role of governmental delegations. Such a double requirement could be met by proposing resolutions for adoption by the plenary of WHA as in committees A and B, but to explicitly welcome within such resolutions commitments independently taken by other partners that would be annexed to the resolution. With such a procedure the other entities keep their full independence by autonomously adopting – according to their internal rules – their declarations to be annexed. There is an interaction between the member states and the other entities in Committee C on the conditions and methods under which to annexe a declaration and the core of the resolution. Member states keep their sovereignty in the final adoption of the resolution in the WHA plenary where other stakeholders cannot vote or intervene.

In short, Committee C would be a workable mechanism to improve consistency of global health action and coordination between many partners while respecting their independence and decision-making structure. The suggestion of a Committee C is *not* to create an NGO Forum within the WHA. At the center of our concern is the governance challenge we set out at the beginning: for the WHO to provide mechanisms and instruments which let it achieve the following:

- Link the new global health actors to the system of multilateral intergovernmental institutions, in particular the WHO;
- Engage in new ways with the many non-health actors that can influence health both positively and negatively;
- Perform its coordination function in relation to the development of legal instruments with a broader range of players.

We wanted to construct a transparency and accountability mechanism for major actors in global health governance and bring their voices *into* the WHA. This seems to us to be critical. Where else could the international health community better debate the policy priorities and approaches of major players? Why not use the existing mechanism and organizational infrastructure of the World Health Assembly? Even though this would only be one of the necessary steps to improve coordination in global health, such a mechanism would help to meet several challenges faced by the current fragmentation in global heath.

References

1. M. Chan, Director-General of the World Health Organization, "The Future of Financing for WHO," introductory remarks at an informal consultation on the future of financing for WHO, January 12, 2010, Geneva, Switzerland, *available at* <http://www.who.int/dg/speeches/2010/financing_who_20100112/en/index.html> (last visited July 1, 2010).
2. D. Fidler, "Architecture Amidst Anarchy: Global Health's Quest for Governance," *Global Health Governance* 1, no. 1 (January 2007), *available at* <ghgj.org/Fidler_Architecture.pdf> (last visited February 8, 2010).
3. N. Ravishankar, P. Gubbins, R. Cooley, K. Leach-Kemon, C. Michaud, D. Jamison, and C. Murray, "Financing of Global Health: Tracking Development Assistance from 1990 to 2007," *The Lancet* 373, no. 9681 (June 20, 2009): 2113-2124.
4. S. Krasner, "Structural Causes and Regime Consequences," *International Organization* 36, no. 2 (Spring 1982): 185-205, at 186.
5. I. Kickbusch, "Global Health Governance: Some Theoretical Considerations on the New Political Space," in K. Lee, ed., *Health Impacts of Globalization* (Basingstoke, U.K.: Palgrave Macmillan, 2003): at 192-203.
6. WHA62.14, *Resolutions of the Sixty-Second World Health Assembly*, World Health Organization, *available at* <http://apps.who.int/gb/ebwha/pdf_files/WHA62-REC1/WHA62_REC1-en-P2.pdf> (last visited July 1, 2010).
7. World Health Organization, *WHO Framework Convention on Tobacco Control*, HD 9130.6, 2005, *available at* <http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf> (last visited July 1, 2010).
8. World Health Organization, International Health Regulations, WHA58.3, *available at* <http://www.who.int/ihr/9789241596664/en/index.html> (last visited April 23, 2008).
9. G. Silberschmidt, D. Matheson, and I. Kickbush, "Creating a Committee C of the World Health Assembly," *The Lancet* 371, no. 9623 (2008): 1483-1486.
10. G. Wiseman, "Polylateralism and New Modes of Global Dialogue" Discussion Paper No. 59, Leicester, Leicester Studies program.
11. World Health Organization, *The First Ten Years of the World Health Organization* (Geneva: WHO Press, 1958): at 40.
12. B. Bull and D. McNeill, *Development Issues in Global Governance: Public-Private Partnerships and Market Multilateralism* (Oxford: Routledge, 2006): at 69-78.

13. Constitution of the World Health Organization, Forty-Fifth Edition, October 2006, *available at* <http://www.who.int/governance/eb/who_constitution_en.pdf> (last visited July 1, 2010).
14. J. Sturtevant, A. Anema, and J. Brownstein, "The New International Health Regulations: Considerations for Global Public Health Surveillance," *Disaster Medicine and Public Health Preparedness* 1, no. 2 (2007): 117-1121.
15. "Statement by Dr. Keiji Fukuda on Behalf of WHO at the Council of Europe Hearing on Pandemic (H1N1) 2009," posted January 26, 2010, *available at* <http://www.who.int/csr/disease/swineflu/coe_hearing/en/index.html> (last visited July 1, 2010).
16. See Bull and McNeill, *supra* note 12.
17. See Chan, *supra* note 1.
18. See World Health Organization, supra *note* 11, at 53.
19. V. Berridge, K. Loughlin, and R. Herring, "Historical Dimensions of Global Health Governance," in K. Buse, W. Hein, and N. Drager, eds., *Making Sense of Global Health Governance: A Policy Perspective* (Basingstoke, U.K.: Palgrave MacMillan, 2009): at 34.
20. D. McCoy, G. Kembhavi, J. Patel, and A. Luintel, "The Bill and Melinda Gates Foundation's Grant-Making Programme for Global Health," *The Lancet* 373, no. 9675 (2009): 1645-1653.
21. L. Magnussen, J. Ehiri, and P. Jolly, "Comprehensive Versus SelectivePrimary Health Care: Lessons for Global Health Policy," *Health Affairs* 23, no. 3 (2004): 167-176.
22. L. Garrett, "The Challenge of Global Health," *Foreign Affairs* 86 (2007): 14-38, at 21.
23. A. Slaughter, "The Global Governance Crisis," *The InterDependent* (Spring 2006): at 32.
24. I. Kickbusch and G. Lister, *European Perspectives on Global Health: A Policy Glossary*, (Brussels: European Foundation Centre, 2006): at 7-9.
25. D. Stuckler and M. McKee, "Five Metaphors about Global-Health Policy," *The Lancet* 372, no. 9633 (July 12, 2008): 95-97.
26. Commission on Macroeconomics and Health, *World Health Organization, Macroeconomics and Health: Investing in Health for Economic Development* (Geneva: WHO Press, 2001).
27. Commission on Social Determinants of Health, World Health Organization, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, *available at* <http://www.who.int/social_determinants/thecommission/finalreport/en/index.html> (last visited July 1, 2010).
28. L. Garrett, *The Future of Foreign Assistance Amid Global Economic and Financial Crisis: Advancing Global Health in the U.S. Development Agenda*, Council on Foreign Relations, Washington, D.C., 2009.
29. Organization for Economic Co-Operation and Development, *The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action*, *available at* <http://www.oecd.org/dataoecd/11/41/34428351.pdf> (last visited July 1, 2010).
30. *International Health Partnership Plus (IHP+), available at* <http://www.internationalhealthpartnership.net/en/home> (last visited July 1, 2010).
31. *Effective Aid, Better Health: Report Prepared for the 3rd High Level Forum on Aid Effectiveness*, in Accra, Ghana, September 2-4, 2008 (Geneva: WHO Press), *available at* <http://www.who.int/hdp/publications/effectiveaid_betterhealth_en.pdf> (last visited July 1, 2010).
32. In this publication.
33. I. Kaul and R. Mendoza, "Advancing the Concept of Public Goods," in I. Kaul, P. Conceição, K. Le Gouiven, and R. Mendoza, eds., *Providing Global Public Goods: Managing Globalization* (New York: Oxford University Press, 2008): at 78-111.
34. See Kickbusch, *supra* note 5.
35. See Ravishankar et al., *supra* note 3.
36. I. Kickbusch, G. Silberschmidt, and P. Buss, "Global Health Diplomacy: the Need for New Perspectives, Strategic Approaches and Skills in Global Health," *Bulletin of the World Health Organization* 85, no. 3 (2007): 230-232.
37. I. Kickbusch, "Moving Global Health Governance Forward," in K. Buse, W. Hein and N. Drager, eds., *Making Sense of Global Health Governance: A Policy Perspective* (Basingstoke, U.K.: Palgrave MacMillan, 2009): at 320-321; S. Bartsch, W. Hein, and L. Kohlmorgen, "Interfaces: A Concept for the Analysis of Global Health Governance," in W. Hein, S. Bartsch, and L. Kohlmorgen, eds., *Global Health Governance and the Fight against HIV/AIDS* (Basingstoke, U.K.: Palgrave Macmillan, 2007): at 30-32.
38. Editorial, "Beyond Copenhagen: Dialogue, Not Diktat," *The Guardian*, December 21, 2009, at 30; *The Economist Online,* "Seeking Compromise: Slow, If Any, Progress Is Being Made at the Copenhagen Climate-Change Talks," December 15, 2009, *available at* <http://www.economist.com/sciencetechnology/displaystory.cfm?story_id=15106331> (last visited February 11, 2010; log-in required); S. Fakir, "Was Copenhagen the Death of Multilateral Environmental Agreements?" *African News*, January 2010, *available at* <http://allafrica.com/stories/201001130800.html> (last visited July 1, 2010).
39. R. De Vogli and D. Gimeno, "The G20 and the Three Global Crises: What Prospects for Global Health?" *Journal of Epidemiology and Community Health* 64 (2010): 99-100.
40. M. Naim, "Minilateralism," *Foreign Policy* 173, no. 2 (July/August 2009): 135-136.
41. The *Commission on Global Governance, Our Global Neighbourhood* (Oxford: Oxford University Press, 1995): at 4.
42. W. Hein, S. Burris, and C. Shearing, "Conceptual Models for Global Health Governance," in K. Buse, W. Hein, and N. Drager, eds., *Making Sense of Global Health Governance: A Policy Perspective* (Basingstoke, U.K.: Palgrave MacMillan, 2009): at 72-98.
43. D. Davenport, "The New Diplomacy," *Policy Review* no. 116 (December/January 2003): 17-31.
44. N. Long, ed., *Encounters at the Interface: A Perspective on Social Discontinuities in Rural Development* (Wageningen: Agricultural University, 1989): at 1-2.
45. S. Burris, P. Drahos, and C. Shearing, "Nodal Governance," *Australian Journal of Legal Philosophy* 30 (2005): 30-58.
46. See Discussion Paper, *supra* note 10.