A Game Change in Global Health: The Best Is Yet to Come

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ABSTRACT

Health will continue to gather strength as a global public domain if it links itself strategically with other transnational agendas and strengthens its political ability to produce global public goods for health. Three new political spaces offer opportunities to take the global health agenda a significant step forward: the emerging new development paradigm, the post-2015 debates at the United Nations and the dynamics created through the increasing trans-border health challenges the World Health Organization (WHO) must deal with under conditions of globalization. Presently there are concerns whether the major initiatives that have boosted global health in the last 20 years will continue to grow and attract sufficient funding. But the more pertinent question is whether they are still suited to address the major concerns global health faces between now and 2030. In addition many of the global health challenges can only be addressed through actions in sectors other than health and by facing the inherently political nature of health as well as strong opposition from parts of the private sector. A well-financed and rules based governance system — adapted to complex multilateralism — is needed to manage, complement and integrate the many issue-based initiatives. The next era of global health will be judged by its political capacity to ensure global health security, build universal health coverage, address the commercial determinants of non-communicable diseases and reduce global health inequalities. This will require a focus on producing global public goods for health (GPGH) through strong international organizations, in particular the WHO, supported by governments who have the political will and the institutional capacity to practice smart sovereignty, reach beyond the heath sector and engage with non-state actors.

Key Words: Global health, global public goods for health, new development paradigm, smart sovereignty

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THE STRATEGIC RELEVANCE OF GLOBAL HEALTH

The governance challenges for global health are deeply political challenges. The positioning of health in a global and interdependent world has changed profoundly over the last 20 years related to processes of globalization and major power shifts within and between countries, sectors and organizations. This makes a number of existing development frameworks obsolete. The forging of global governance will increasingly depend on the support and willingness of the emerging economies and rising powers[1]; this was amply illustrated at negotiations related to climate change in Copenhagen 2009, the stalling of the Doha round of talks on trade as well as in negotiations on "viral sovereignty" within health.[2] Effective global governance will also increasingly depend on the compliance of the corporate sector with global rules combined with a readiness to act more responsibly and in adherence to human rights.[3]

Health continues to gather strength in the global domain: it remains a major contributor to development, and it has become integral to the political transnational agendas of many states and the commercial transnational agendas of many business sectors. These agendas play out and overlap: the *security agenda* driven by the fear of global pandemics or the intentional spread of disease; the *foreign policy agenda* which prioritizes national interests; the *economic agenda* which sees the health sector as a USD 6.5 trillion global growth industry; and finally the *social justice agenda*, which advocates for health as a social value and human right.[4]

This review takes the view that there is both a need and an opportunity for a game change in global health towards a more political paradigm which is committed to the production of global public goods for health (GPGH). Three political spaces[5] to take such an agenda forward are at hand: the emerging new development paradigm, the post-2015 debates at the United Nations and the dynamics created through the increasing trans-border health challenges the World Health Organization (WHO) must deal with under conditions of globalization. This expanding agenda was well documented at the 2013 66th World Health Assembly (WHA66) which had to deal simultaneously with WHO reform and finance, the mechanisms to address the new priority of non-communicable diseases (NCDs), the post-2015 process with its ensuing health priorities and call for universal health coverage, the experiences gained with avian influenza A (H7N9), the stalling of polio eradication, the threat of anti-microbial resistance and finally the outbreak and spread of the MERS Coronavirus (nCoV).[6] The realization has grown in these debates that the major global health challenges

can no longer be resolved within the confines of *global health governance* but need to become part of a much larger agenda of *global governance for health and sustainability.* In response WHO has ventured into areas such as the social determinants of health and health in all policies. Yet despite strong lip service, the political breakthrough in support of such approaches has not yet occurred, and the organization continues to face great difficulties in working with other sectors.

END OR START OF AN ERA?

It is helpful to start from the strategic construct of a "global public health domain" from which to position health more broadly and more politically. A "global public domain" is defined by Ruggie as "an institutionalized arena of discourse, contestation and action organized around the production of Global Public Goods (GPG). It is constituted by interactions among non-state actors as well as states (…). It differs from anything in the past that might resemble it in its dynamic density, and by operating in real time."[7] The global public health domain goes beyond the interstate realm and presently encompasses an extraordinarily dense range of initiatives and institutions: international organizations, sectors and agencies in countries, development banks, global health initiatives, hybrid organizations, alliances, civil society, private industry, philanthropies, academic institutions, professional associations and dedicated individuals, some with significant power. Fidler has termed this development "global health's political revolution".[8]

This "golden era of global health"[9] of the last 20 years has been so described because the increase of actors has been accompanied by the significant and consistent growth of financial contributions for the large issue-based global health initiatives, which have led to many innovations and saved many millions of lives. As global challenges mount and money seems to get scarcer, the concern grows that the expansion of global health is coming to an end. There are also increasing concerns that the WHO, global health's core agency, has been significantly and dangerously weakened through this development.[10] In marked contrast Mark Dybul, the head of the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM), is highly optimistic and sees global health at the "cusp of a breakthrough because of a remarkable series of confluences"[11] which would enable unprecedented steps forward in fighting major diseases.

To some extent both perspectives are valid: the traditional financial transfers by Western governments have indeed been reduced and could

drop further. Yet the flows of non-traditional development assistance (NTDA) have nearly quadrupled from an estimated 8.1 percent of total development assistance in 2000 to 30.7 percent of the total in 2009.[12] In global health NTDA comes primarily from philanthropists such as the Bill & Melinda Gates Foundation (BMGF), a long list of organizations and philanthropies with new financing models and gradually more support from the BRICS countries* and other middle-income countries. The latter takes many different forms and cannot yet be fully assessed. The GFATM and the Global Vaccine Alliance (GAVI) have been very successful with the mixed financing models they have developed. Domestic funding of health systems is also increasing dramatically in many countries: for example domestic funding on HIV has now exceeded international investments, as a report by UNAIDS documents.[13] Finally the private for profit health sector is expanding significantly in both developed and developing countries.[14]

But the "golden era of global health" also went hand-in-hand with a disregard of more political and structural goals in favour of technical solutions — be they bed nets, vaccines, retroviral drugs or contraceptives. This has been a general tendency in development approaches after the end of the cold war,[15] but in global health it has been particularly pronounced due to the nature of the medical enterprise and its humanitarian base. This approach has been further reinforced by the hegemony established by the BMGF in the global public health domain. As the authors of a recent study state, "The ubiquity of the foundation in its areas of interest almost inevitably dampens debate".[16] This review argues that the ability to produce GPGH lies at the core of the next era of a more politically minded global health. It is urgent to embark on a critical debate on global health's direction because the challenges on the horizon cannot be resolved through relying on the present approaches. This game change in global health will need to be as radical as the changes introduced by AIDS to the global health arena three decades ago.[17] Such change will require both a change in the approaches prioritized within the system of *global health governance* and its health focused institutions and a determined move into other sectors based on a broader commitment to the *global governance for health and sustainability.* It will also demand a shift from the technical realm into the realms of governance and politics and it will require political acumen to make use of unique opportunities and "new political spaces".[5]

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* Brazil, Russia, India, China, and South Africa

A GLOBAL PUBLIC GOODS FOR HEALTH APPROACH

Global health as a term refers to "those health issues which transcend national boundaries and governments and call for actions on the global forces and global flows that determine the health of people."[18] This significantly expands the global public health domain from the global health initiatives to a wide range of other sectors, actors and concerns, including not only the global flows of viruses, health services, people and products but also global financial flows and their impact on health in the face of globalization. The issues of interest and power — the political and commercial determinants of health — are not sufficiently present in much of the global health literature. At the same time reports on successful technical interventions will usually include a category along the lines of "political will" as if it were one technical component among others. Of course some non-governmental organizations (NGOs) are adamant that health is political[19], and recent analysis of the impact of austerity politics on health in Europe also makes clear reference to the political determinants[20] as do some analyses of the NCD epidemic.[21]

For a politically astute approach to global health we still need to establish a better conceptual link between the cross-boundary nature of globalization and the many dimensions of health. Only then can we develop governance structures and mechanisms that can respond adequately to globalization's extensity, intensity, velocity and impact.[22] Most definitions of global health do not fulfill this requirement, and much of the debate applies a mind frame that has been characterized as "methodological nationalism" — basing analysis on the notion that social phenomena can be conceptualized around the boundaries of the nation-state rather than on the highly mobile global flows and the complexities of interdependence.[23] This national bias makes it particularly difficult to deal with the commercial determinants of health and the increasingly trans-boundary nature of the unhealthy commodity industries as the NCD debate clearly shows. The WHO Director General Dr. Chan stated at the end of the WHA66 that never before had delegations from WHO member states come under such pressure from trans-national private companies.

This review argues that in order to strengthen individual countries in their response to the trans-boundary nature and impacts of globalization on health, a strong commitment to the production of GPGH has become a political imperative. While the initial debate on GPG concentrated on an economic rationale of market failure, recently approaches to GPG have been more politically driven. GPG are defined pragmatically along three characteristics: rules that apply across borders, institutions that supervise and enforce these rules, and the benefits that accrue without distinction between countries.[24] We know well that global health risks cross borders and manifest themselves

at the national and local level — be they contagious disease outbreaks, NCD or health equity challenges — and because of this cross-border nature, no country alone can prevent their occurrence and or deal with their externalities. Fighting the spread of viruses without cooperation can be near impossible — the same applies increasingly in relation to the response to multinational companies that harm or endanger health. It is important to underline that in an age of interdependence GPG do not erode national sovereignty — they strengthen it as states decide jointly on their commitments in the face of pressures they could not face successfully alone. Trail blazer countries with strong political will can pave the way for the global community as Australia has done in fighting the tobacco industry on the issue of plain packaging.[25]

In the global public health domain we have an organization that can establish rules that apply across borders. WHO is unique among global health organizations because of its treaty making power; in November 2011 the Executive Board of the WHO underlined that "the intergovernmental nature of WHO's decision-making remains paramount; the development of norms, standards, policies and strategies, lies at the heart of WHO's work." So far WHO has only adopted two major binding health agreements — the International Health Regulations (IHR) and the Framework Convention on Tobacco Control (FCTC) — and in relation to both there are major challenges in national implementation. Still there are a growing number of proposals to develop other binding frameworks for health — for example in relation to research and development, marketing to children, alcohol, fraudulent medicines and antimicrobial resistance. There has also been a proposal for an overarching Framework Convention on Global Health — which in fact echoes many elements enshrined in the WHO Constitution. A wide range of rules established in the global health arena have a GPG character; they include norms, knowledge and technologies, international regimes, disease surveillance and control, policies and standards. They do have benefits that accrue without distinction between countries — even though a range of countries would need additional support to be able to establish the necessary mechanisms at country level. But while WHO can establish rules and supervise their implementation (countries do have a responsibility to report), one of its key weaknesses is that it cannot enforce these rules.

Whereas much of the global health innovations and initiatives focus on how to address market failure, the recent Global Risks Report 2013 has identified global governance failure as a critical component of all the global risks it analyzes, including (as a health example) the challenge of multidrug resistance. The report highlights how global governance needs to be better integrated with national responses[26] — even when agreement has been reached at the global level most GPG — also in health — depend on

national implementation. This echoes Kaul (2013), who suggests that one of the most productive ways to strengthen global governance is to put in place mechanisms that support GPG at both the national and the global level. A GPGH approach generates the need for "smart sovereignty" — this means that in view of increasing interdependence in a global world it is within countries' enlightened self-interest to engage in international cooperation and support and implement international agreements which ensure benefits for their citizens.[27] For example, states will only be able to address the global tobacco epidemic by rigorous implementation of the FCTC, and they will only be able to successfully restrict disease outbreaks if each and every state fulfills its obligations under the IHR.[28]

THE CHANGE IN THE DEVELOPMENT DISCOURSE

GPG usually face the same problems as public goods at the national level: nobody is willing to pay unless there is a mechanism (i.e., taxation) to enforce contribution. This means a GPG approach is hampered by two difficulties: there is the fear of losing sovereignty (i.e., the control of one's own territorial policy decisions) through accepting the joint governance of GPG, and there is the fear of the responsibilities for investment and financing at the global and at the national level that go with a GPG approach. At the global level the issue of just pricing also needs to be addressed — one of the reasons the Kyoto Agreement finally failed.[29] The global public health domain has spearheaded models to show that the financing and governance of GPG is not exclusively a matter of governments — indeed in some areas of GPGH provision, such as the access to treatment for HIV/AIDS, this has been undertaken by a wide range of stakeholders from the public and the private sector and through new mechanisms such as the GFATM and a levy on airline tickets. This underlines Ruggie's position on what constitutes a global public domain. Because the concern for the financing of GPG is part of the new dialogue on development aid, it becomes an important political space for global health interests. Shafik (2011), now vice president at the International Monetary Fund (IMF), projects aid to become a "catalyst for financing global problem solving".[30] The emergence of a new development model which maintains that "the path is potentially set for the design of a new kind of development assistance and global public policy"[1] will have a significant impact on the global public health domain. It will consist of two major streams: international solidarity through "global issue networks" to help the poorest and actions to tackle GPG such as climate change, conflict resolution and public health.[1]

The purpose of aid is changing as the geography of poverty changes. The recent United Nations Development Report highlights that broad "global rebalancing" is taking place with about 40 countries dramatically improving the living conditions, health and education of their people; this can free funding for the production of GPG.[31] Aid dependence will fall for most countries — as poverty decreases, direct investments and workers' remittances become more important; aid, foreign and commercial interests will increasingly be linked. Many poverty challenges are now issues of national redistribution related for example to tax rates rather than donor support[12] as governments of developing countries are committing more of their own resources to health.[32]

The BRICS countries can provide examples from their own recent development experience on how to invest in growth, address major health issues and determinants or provide access to health care in a resource poor environment. Brazil is such an example (also hailed by the World Bank) which has raised 20 million people out of poverty in its own country and has just recently announced that it plans to cancel or restructure USD 900m worth of debt in 12 African countries, as part of a broader strategy to boost ties with Africa. As many of the BRICS and a range of other middle- and low-income countries increase their domestic health investment they also become rich enough to buy advice in the private health consultancy market, as China has done in the process of its health care reforms. Developing countries are entering an 'age of choice'**:** they shop for development models and partners.[32] Increasingly they will seek expertise and experience as well as independent and autonomous training systems rather than financial assistance. Providing lawyers is quite different from providing bed nets — and building schools of public health is different from sending project consultants. Countries will not only expect different things from aid organizations (some of which are already refocusing their work accordingly), international organizations and development banks — they also want voice and power to define global agendas and the GPGH that are of high relevance for them.[33]

THE POST-2015 AND THE SUSTAINABLE DEVELOPMENT GOALS PROCESS

The post-2015 agenda is a critical political space where a "new global partnership" — UN Secretary-General's High-Level Panel of Eminent Persons (HLP) report[34] — is being defined and forged, also in global health. The UN has taken a leadership role in global health on three occasions: in defining the health related millennium development goals (MDGs) and in

organizing two key debates at the UN General Assembly, on HIV/AIDS in 2000 and on NCDs in 2011. It has the opportunity to do so again in 2015 in relation to the future heath agenda and the production of GPGH. In this process health relates to two big sustainability challenges: the one set by the Rio+20 Declaration (2012)[35] which is to "manage the world's production and consumption patterns in more sustainable and equitable ways"; the other which maintains that reducing poverty can no longer be seen separately from the need to protect "earth's life support".[36] This provides an excellent entry point to discuss health challenges in terms of GPG: it relates to issues such as health security and the recent outbreaks of avian influenza A (H7N9) and MERS Coronavirus (nCoV); the global spread of NCDs; the threat of anti-microbial resistance; and unacceptable and unsafe working conditions as in the textile factories and mining industries of the developing world. Health must build the bridges to the production of other GPG required to ensure in health: for example food, water and energy.[37] Many of these face similar challenges with universal access (i.e., water as a human right) as does the debate on universal health coverage. None of the health goals — no matter how defined — can be reached by the health sector alone and are all dependent on other goals yet to be determined including reduction of poverty, just governance and equity.

In contrast the proposal of the HLP[38] leaves much to be required. In its health proposal *Goal 4: Ensure Healthy Lives* it maintains the priorities of the MDGs and adds sexual and reproductive rights, indeed an important addition; the need for UHC is mentioned in the text that accompanies the goal proposal; NCDs are added on to the list of priority communicable diseases HIV/AIDS, Tuberculosis, Malaria and (again an addition) neglected tropical diseases (NTDs). There is no reference to an urgent challenge such as anti-microbial resistance or outbreaks which require global collective action and would need to be approached with a GPGH mindframe.

One forward-looking suggestion has been to relate people's health to the sustainable development agenda through a vision that links Healthy People with those of a Healthy Planet.[39] Another has been an adapted definition of sustainable development by David Griggs and colleagues (2013): "Development that meets the needs of the present while safeguarding Earth's life support system, on which the welfare of current and future generations depends."[36] They propose six goals which "manage trade-offs and maximize synergies" and cut across economic, social and environmental domains: *thriving lives and livelihoods, sustainable food security, secure sustainable water, universal clean energy, healthy and productive eco systems, governable and sustainable societies*.[36] In this approach health is a subcategory but clearly cross-cutting. This review argues that it will be

critical in the post-2015 and sustainable development goal (SDG) negotiations to present health not as a sectoral, functional and technical area but as an overarching fundamental goal which is a cornerstone of sustainable development in the 21st century and is essential in both a normative and a strategic sense to any future post-2015 framework that might emerge. Its deep relations to human rights, equity and governance need to be highlighted — all of which relate to the provision of GPGH.

Governments — says the WHO Constitution — have a responsibility for the health of their people — it does not specify ministries of health. It also implies a political commitment. The post-2015 and the SDG process will shape global governance for health in the decades to come but will be negotiated by governments, not sectors — meaning mainly representatives of the ministries of foreign affairs. Health must be well prepared as to how to enter this highly politicized and competitive diplomatic arena because it is not yet guaranteed that health will be prominently positioned and it is even less ensured that GPG approach to the health challenges of the 21st century will receive consideration. WHO will have a lead responsibility in shaping how health will be positioned and framed — it will need to strengthen its working group on the post-2015 agenda and its interface with the mechanisms that emerge after the 2013 UN General Assembly through a strong presence in New York. The focus of the post-2015 debate on health will need to focus on global governance for health and sustainability, meaning action which will impact on health and its determinants.

UN ORGANIZATIONS AS NORM BUILDING HUBS OF NETWORK GOVERNANCE

The global public health domain has become a sophisticated system of "complex multilateralism" and network governance defined by a high degree of innovation, some complementarity and a fair amount of competition. At first the "new" and "old" forms of governance were juxtaposed to imply that the new forms — such as public private partnerships, hybrid organizations, alliances, funds and the like — were more effective than the intergovernmental organizations such as the WHO. A key argument for the many new partnerships was that they were innovative, inclusive, flexible and quick, results focused and therefore much more effective in performance.[40] But what initially seemed a zero-sum game in which governmental actors would lose their rule setting authority to actors with less legitimacy and less willingness to regulate — also within health — has not come about to the extent that was feared and partly wished for.

In the new century WHO — while being described as weak and ineffective — actually embarked on a number of key rule setting GPG initiatives (e.g., FCTC, IHR, Pandemic Influenza Preparedness (PIP) Framework); provided clear guidance for the financing of health systems; responded to major disease outbreaks and externalities (SARS, H1N1) and launched new value driven initiatives such as the Report of the Commission on Social Determinants of Health. Health was further strengthened during the debates at the UN on the MDGs, on HIV/AIDS and on NCDs. These activities at the UN, the WHO and many other international organizations are expressions of network governance for global health that expand the global public health domain, fuel its dynamism and support the production of global norms[41] such as the right to health.

Such "dynamics that undermine, cross and mix boundaries"[42] in a continuously evolving form of network governance with a very similar expansion and unstructured plurality of actors can also be seen in climate governance.[43] The organizations no longer coordinate in the 20th century sense of the word; instead they manage a complex adaptive global system of many interests and voices by enabling ongoing feedback loops and consensus building. This new multilateralism requires skills in relationship building and negotiation and explains the growing interest in the field of global health diplomacy[44] — everyone has become a health diplomat in some fashion.[45] Such a dynamic global policy domain must be nurtured and supported by clear rules of engagement, transparency and accountability — this is the 21st century approach to interpreting Article 2 of the WHO Constitution to "act as the directing and coordinating authority on international health work". For example, over 3000 registered participants attended the WHA66, and over 100 side events were organized. Twitter and social media reporting abounded. The organization must plan its governance processes with a mind to acting as the crucial hub for setting global health norms, which are then taken to other bodies and organizations. This is a major part of the stewardship function within network governance.

A weakening of multilateral organizations such as the WHO would give powerful governments as well as other actors even more scope to do as they please. That is why WHO reform has become so important: the organization sets global health norms and priorities, and it needs to be strengthened to fully apply its normative and legal base to develop and strengthen GPGH. With a GPGH focus the staffing composition of the organization will need to change: it will require lawyers, policy analysts and economists. For example it will need to significantly expand its capacity in international law as it relates to health — this would include public international law (e.g., international criminal law, humanitarian law and human rights law), private

international law and supranational law. Specialized areas include trade laws and intellectual property laws. WHO should also strengthen its currently weak and unsystematic role in the collection of relevant national health laws as well as in giving or coordinating legislative advice to its Member States which are otherwise often challenged in using their national health regulatory space vis-a-vis their international obligations. The role of the private sector in health will expand exponentially over the next 20 years — WHO will need staff who understand the transnational health industry, can analyze its strategies and its economic and political impact and feed this information back to member states.

TRANSPARENCY AND ACCOUNTABILITY WITHIN THE GLOBAL PUBLIC HEALTH DOMAIN

A critical next step in global health governance will be to strengthen accountability and transparency for all actors, including NGOs. Network governance requires what John Rawls has termed a "moral concept of reciprocity" — global health governance needs to move towards an approach in which external accountability will be required in order to maintain legitimacy. The global public health domain requires a reliable and sustainable system of distributed governance between the global health organizations that presently exist. Mandates and responsibilities need to be clearly presented, cooperation encouraged by member states and other actors and transparency and accountability ensured. Keohane (2008) draws attention to the fact that contrary to what one might believe, intergovernmental organizations along with weak states are among the most accountable entities in world politics.[46] In contrast corporations, trans-governmental networks and powerful states are much less accountable — for the global public health domain we must add large philanthropies. Accountability is inversely linked to power, and the more powerful organizations or states are — also in the international and transnational realm — the less accountable. Non-state actors in the global public health domain have gained significant influence through a combination of resource based and results based legitimacy fuelled through ideas and innovation. The scrutiny paid to many of these actors is not as strong as that for international organizations; indeed there are increasing reports that their hegemony prevents critical analysis. The new actors and hybrid organizations all have systems of accountability to their own members, boards and shareholders — but there is no system of accountability for their impact on the global public health domain in its totality, its members, its agendas and its funding streams.

The transparency requested from the WHO in the context of its reform process needs to be matched with a mechanism for mutual accountability within the global health arena. Nascent and uncoordinated efforts exist: reporting on donor contributions to global health, assessment of agencies by donors, reporting by the UN Special Rapporteur on the human right to health, NGO reports on implementation of treaties, norms and standards, assessment of MDG implementations and the Commission on Information and Accountability for Women's and Children's Health. One way forward could be for the WHO to propose an independent accountability agency or commission which would work on criteria jointly developed by states together with other global health actors. These would assess the organizations according to their mandate and their impact on the progress in the global public health domain as a whole. The reports of such an independent agency or commission would be widely available and presented for discussion to a legitimate institutional interface — both at the WHO and the UN General Assembly. A proposal to locate such an interface within the context of the WHA called Committee C was put forward a couple of years ago[47] and could provide a basis for further discussions. Finally, as the world changes ever more rapidly and health continues to be ever more important, a new type of annual world health report could be envisaged which provides an analysis of the global public health domain, its actors, is financial flows and its political relevance.

FUNDING MODELS FOR GPGH

It is encouraging that WHO is seeking new approaches to ensure the funding of its core functions which produce GPGH — and that there is even discussion on increasing the assessed contributions. Yet some more radical options should be considered that relate to other funding streams in the global arena. GPGH that serve all actors — not just states — should be financed by all: people, governments and industry, because the stability and the rule of law provided through a strong multilateral system benefits all. Therefore a new approach is needed to cover a significant part of the funding that is required to ensure the implementation of politically agreed GPGH at all levels of governance. Global health organizations such as the GFATM are already engaged in the financing of GPGH — such as the sustained care and treatment of the millions of people with HIV/AIDS — through a wide range of public and private partners. Governments, in cooperation with the development banks and the private sector as well as major foundations, can develop models for this in the context of the post-2015 debate, building on

existing experiences with approaches in the global public health domain such as UNITAID, the International Finance Facility for Immunization (IFFI), Advanced Market Commitments (AMC), Debt2Health, "micro-contribution" and proposals such as a Currency Transaction Levy (CTL).[48] Other models exist in the field of climate change and agriculture which could serve the global public health domain well in the discussions on GPGH.[27,49]

Ideally the post-2015 agreements for health would include financing mechanisms which identify clear GPGH packages with pooled reliable funding mechanisms from various levels of governance and a wide range of contributors. Funding models might also include cooperation of different agencies on GPGH packages — for example between agencies responsible for matters related to anti-microbial resistance. The global health market, with its present volume of USD 6.5 trillion, benefits significantly from WHO's effort on universal health coverage, access to vaccines and medicines, product safety and classification of products and diseases. De-Tax is a "proposal to earmark a share of VAT Taxes generated by participating businesses for health systems development" and is being discussed by the G20 countries. It clearly needs a mechanism detailing how the health industry is required to contribute to the provision of GPGH.

A "GOLDEN ERA OF GLOBAL HEALTH" WORTHY OF THAT NAME IS YET TO COME

All governance at the global level — global health governance and global governance for health and sustainability — needs to be supported by "the creation or reform of national institutions."[50] The debate on global governance has neglected national institution building for global collective action: good global health begins at home. Governance for global health at national and regional levels is critical. States gain strength and legitimacy when they practice smart sovereignty and act collectively, restricting the power of largely unaccountable actors such as transnational corporations at the global level; this they did in health when they adopted and then ratified the FCTC. It requires structures and mechanisms that engage sectors and actors at the national level in preparation for international negotiations, meaning strong departments of global health in ministries of health and intersectoral mechanisms that work towards policy coherence in global health. Kaul calls these "National Programmes of international cooperation"[27] — in global health we call them *National Strategies for Global Health.* These are strategy papers that are produced jointly across various sectors of government — sometimes with the involvement of other actors — to develop a

coherent approach to global health action and negotiations.[51] In addition capacity building in global health diplomacy allows all actors to better understand the global policy process as well as the implications and benefits of smart sovereignty.[27,52] It follows that one of the roles of the WHO is to support countries to build the capacity to practice *smart sovereignty* for health in order to strengthen their understanding of and commitment to GPGH.

Frequently because of many national pressures, countries will not act on their own initiative — that is why the agenda setting role of international organizations and the voice of global civil society combined with academia to provide evidence of effectiveness has become so critical at the global level. Rules need to be in place which ensure that negotiations in the global public health domain are fair and just; the success of the recent PIP negotiations has illustrated how central this is to reaching agreements[2]; inclusive mechanisms for consultation with broad participation of the many actors in the global public health domain need to be ensured through network governance and good stewardship. But in order to act we also require a better understanding of the dynamics of the global public health domain: how political, economic and commercial forces affect the choice of policies and their distributional effects on health. One way to move forward could be for WHO to establish a second commission on Macro Economics and Health to explore the global financial environment as it relates to health, including the growth of the global health industry. The political and economic environment has changed so significantly since the report of the first such commission[53] ten years ago that this would provide a much needed basis for discussions of a global health approach for post-2015 which is concerned with "those health issues which transcend national boundaries and governments and call for actions on the global forces and global flows that determine the health of people."[18]

We are witnessing a convergence of a set of key principles that form a global health ethics in a challenging narrative of rights and justice which is beginning to be reflected in the debates on post-2015. The next era of global health will be judged by its political capacity to ensure global health security, build universal health coverage, address the commercial determinants of health and reduce global health inequalities. This will require a focus on producing GPGH through strong international organizations, in particular the WHO, supported by governments that have the political will and the institutional capacity to practice smart sovereignty, reach beyond the heath sectors and engage with non-state actors. The best is yet to come.

Acronyms List:
BMGF = Bill & Melinda Gates Foundation
FCTC = Framework Convention on Tobacco Control
GFATM = Global Fund to Fight Aids, Tuberculosis and Malaria
GPG = global public goods
GPGH = global public goods for health
HLP = UN Secretary-General's High-Level Panel of Eminent Persons
IHR = International Health Regulations
MDGs = Millenium Development Goals
NCD = non-communicable disease
NTDA = non-traditional development assistance
PIP = Pandemic Influenza Preparedness (PIP) Framework
SDG = sustainable development goal
WHA66 = 66th World Health Assembly

Conflicts of Interest: Ilona Kickbusch was a WHO staff member between 1981 and 1998. Presently she advises several WHO programmes. The Global Health Programme is involved in Global Health Diplomacy training with several parts of the organization. She has been an advocate of a global public goods approach to global health for many years.

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