Meeting Summary: Centre on Global Health Security

Competing Visions of Global Health Governance

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POLICY RECOMMENDATIONS

These recommendations are based on two assumptions underpinning the project. First, that if 'health is global', then this requires new forms of global cooperation and oversight. This is the space known as global health governance (GHG). Second, that ideas matter because they shape the way we see the world and how we define our interests. Five key ideas, frames or visions are dominant in global health governance: development, economics, evidence-based medicine, rights and security.

Key recommendations:

- Successful GHG must be grounded in an acceptance that it is an inherently political space, and one which is not limited to technical solutions based on 'best practice', cost effectiveness or evidence.

- GHG is not based on a single underlying logic. Rather it is characterized by competing frames, each with its own logic, language and preferred policy pathways. This creates a complex and contested policy space where different frames (and the worldviews they represent) vie for dominance. GHG should actively engage with the divergent problem definitions and policy solutions these frames imply.

- Smart advocacy can be developed where an issue can be strategically framed in different ways to appeal to different audiences within specific contexts and timeframes, in order to achieve desired policy outcomes.

- Policy can be advanced through counter-framing. This involves challenging the dominant vision of an issue by framing it in new ways. Examples here include the human rights frame being applied to access to medicines and the reframing of hitherto industry-led economic justifications for not strongly regulating tobacco.

- Framing speaks to sectors outside health (including development, security and macro-economics, for example) and may therefore be used to develop a multi-sectoral approach to GHG.

INTRODUCTION

The Centre on Global Health Security, in collaboration with the Centre for Health and International Relations (CHAIR), Aberystwyth University and the London School of Hygiene & Tropical Medicine (LSHTM), hosted an event on Friday 11 May 2012 entitled 'Competing Visions of Global Health Governance'.

Globalization is changing patterns of health and disease worldwide, as well as the basis on which decisions on health are being made. This has created a challenge for health communities across countries to cooperate more closely, and across a wider range of issues, than ever before. This question, of how we should collectively protect and promote health in an increasingly globalized world, has opened up the policy space known as global health governance (GHG).

Over the past four years, and with support from the European Research Council, a team of researchers led by Professor Colin McInnes (CHAIR) and Professor Kelley Lee (LSHTM) has been exploring this space with the aim of better understanding and explaining why progress on effective GHG has been so difficult, in a project entitled 'The Transformation of Global Health Governance: Competing World Views and Crises'.

This meeting was the first in a series of dissemination events presenting the key findings of the four-year project, which takes a distinctive and innovative approach to understanding and explaining GHG.

Rather than focussing on individual actors, the project conceptualizes GHG in terms of different, and at times competing ideas of the nature and causes of global health problems and the appropriate solutions to them.

The starting point for the project is a recognitionrecognition that these ideas are underpinned by certain normatively based values, ideas and belief systems, thus diverging from public health approaches that have traditionally been dominated by supposedly value-neutral and positivistic problem-solving approaches. In contrast, the project has sought to highlight how other perspectives on global health issues emphasize and de-emphasize different agendas, concerns and policies; and how this can engage different actors, facilitate or inhibit effective governance, and shape the modalities through which it operates.

A systematic analysis of the governance of four key global health issues has been undertaken:

- Access to medicines

- HIV / AIDS

- Pandemic influenza

- Tobacco control

GHG is subsequently understood as a contested and developing landscape that is defined by the interrelationships of ideas – or 'visions' – of who or what heath is for. Issues are presented, or 'framed', in such a way as to fit into one of these visions. We identify five visions and frames:

- Development

- Economics

- Evidence-based medicine

- Human rights

- Security

The key findings can be summarised thus:

- GHG cannot be limited to a narrow range of (infectious) diseases, but is much broader and encompasses an increasing number of issues that directly and indirectly affect health outcomes.

- There is no single underlying logic behind calls for GHG. Rather the space is characterized by a number of competing frames, visions or ideas, each with its own logic and preferred policy pathways. These frames compete not only in the general field of GHG, but within specific health issues.

- No frame is dominant across the entirety of GHG, but different frames have greater levels of policy purchase across different health issues and for some issues a dominant frame can be identified. This suggests that progress on GHG may be better considered as issue-specific rather than a holistic vision.

- These competing visions do not arise naturally but are the result of human agency and often reflect vested interests. But these interests are in turn shaped by these competing visions – they are mutually constitutive.

OBJECTIVES

The principal objectives of the meeting were to present the initial key findings of the project through examining the interplay of the five frames (development, economics, evidence-based medicine, human rights, security) on each of the four global health issues (access to medicines, HIV / AIDS, pandemic influenza and tobacco control); and to stimulate discussion of these findings by both academics and policy-makers and thus provide feedback on the project as a whole.

Session One: Global Health Governance, Access to Medicines and Tobacco Control

Welcome and Introduction: **Colin McInnes**, *Professor, CHAIR, Aberystwyth University; UNESCO Professor of HIV/AIDS Education and Security in Africa*

Opening remarks: **Nick Drager**, *Professor, McGill University; Honorary Professor, LSHTM*

Presentations: **Owain D. Williams**, *Research Fellow, CHAIR, Aberystwyth University*; **Kelley Lee**, *Professor LSHTM; Faculty of Health Sciences, Simon Fraser University; Associate Fellow, Centre on Global Health Security, Chatham House*.

Chair: **Colin McInnes**

Colin McInnes firstly extended a warm welcome to all attendees and went on to express thanks to the Centre on Global Health Security for hosting the event; to the BISA Global Health Working Group for its support and also to the European Research Council (ERC) for funding the project. The latter has been ongoing since January 2009 and the ERC's financial backing has enabled extensive field-work interviews. In this regard, thanks were extended to those interviewees who have provided their thoughts and insights on issues pertaining to GHG specifically and the wider context of global governance broadly defined. Finally, it was noted that the key purpose of the event was to present and discuss key findings of the project through three

basic types of presentation – firstly, an analysis of the current state of GHG; secondly, summaries of the four case studies, located within the matrix of the five overarching project ideas (development, economics, evidence-based medicine, human rights, security); thirdly, some macro-level conclusions and early suggestions about the implications these conclusions might have on the future of GHG.

In his opening remarks regarding the current landscape of GHG, **Professor Nick Drager** noted that overall there had been a change in techniques of global governance because of the rise of new technologies – whereas previously delegations at such organizations as the World Health Organization (WHO) would interact directly with one another face-to-face, this has increasingly been superseded by so-called 'Blackberry Diplomacy'.

He then introduced three frameworks in order to facilitate thinking systematically about GHG.

Firstly, the 'regime framework', which comes out of work on global health diplomacy. Here regime change is brought about through a trigger point of global change, which in turn has an impact on global health, which requires collective action. Examples of such regime change might be SARS or the change in negotiating power of the BRIC countries (which in turn led directly to the Doha Declaration on Public Health, for example). Secondly, the 'instruments framework'. This also evolved out of work on global health diplomacy. Here there are four major categories of instruments: normative, collaborative, operative and advisory, and instruments go from 'soft' to 'hard', and 'least formal' to 'more formal'. Instruments are selected and implemented depending on the particular objective sought. An example of the instruments framework might be the imminent discussion on whether to develop a treaty on research and development in relation to the Framework Convention on Tobacco Control (FCTC). This had its roots in a commission which had about sixty recommendations, which then led to a World Health Assembly (WHA)-negotiated strategy, which then in turn led to a working group proposal that considered whether the next step should be a treaty. This framework carries the possibility of the development of new institutions. Finally, the 'matrix framework', which has evolved out of work with Kent Buse and Wolfgang Hein (eds.), *Making Sense of Global Health Governance*, 2009. This approach examines the functions of GHG (reviewing evidence; agreeing priorities; developing rules/norms; mobilizing finances and resources; service delivery to poor states; intervening in market failures; surveillance and monitoring; accountability and enforcement) in relation to the governance agenda (controlling global 'bads'; promoting global 'goods'; strengthening

health systems; policy coherence) – i.e. 'global health governance for what?' WHO reform could be examined and re-examined within the context of such a matrix, for example – thus, some countries would prefer WHO to focus on rule-making, others might prefer it emphasized development.

In introducing the project, **Colin McInnes** explained that it rested on a set of assumptions:

Firstly, that if 'health is global', then it necessitates new forms of global cooperation and oversight – global health governance (GHG). However, progress on GHG has been slow and limited – why? (particularly as there is an acceptance of the need for it). Secondly, that there are a number of different ideas or visions as to what health is; and that it is the competition between these that helps us to understand why progress on GHG has been limited. However, it was also emphasized that the examination of these visions or ideas is not a rejection of the 'real world' or material factors. Nevertheless ideas shape interests in and understandings of the material world, of who and what health is for and what should be protected by improved health. Thirdly, because there are a number of ideas behind what GHG is, there are necessarily a number of responses to how GHG should be implemented – thus, ideas shape the response.

The initial phase of the project sought to understand what the key ideas in global health might be, through an extensive scoping study followed by a significant number of interviews. It was subsequently concluded that the five key ideas driving GHG are: development, economics, evidence-based medicine, human rights and security. While these aren't the only ideas pertaining to GHG, they are the key ones. It was also noted that there is a degree of fuzziness and overlap between these ideas – but overall they do remain sufficiently coherent as to be identifiable. Health issues are presented – or 'framed' – in such a way as to tie them into one of these broad sets of ideas, and through this gain influence and policy purchase.

The role of the five ideas in shaping GHG was then examined using four case studies: access to medicines, HIV/AIDS, pandemic influenza and tobacco control – spanning the realms of communicable and non-communicable diseases as well as distributive issues. As such, the project is able to take a broader approach than previous comparative studies. The case studies involved both desk-based research and more than 300 key informant interviews.

The project has looked at how and why the issues might be framed in certain ways. Thus, HIV/AIDS was presented to the UN Security Council in January

2000 as a security matter, for example, to gain purchase in a specific policy context.

The project has now entered the final phase, post-fieldwork, of uncovering the macro-level conclusions and possible policy recommendations – the remaining presentations will focus on outlining these.

In this presentation, **Owain D. Williams** examines how the issue of access to medicines has been framed and reframed with specific focus on how economic ideas have been dominant in the issue area. He explained that WHO estimates suggest that a third of the world's population lack access to essential medicines, and this is due to a complex variety of reasons. The significant commercial as well as political interests in the area of global pharmaceuticals – a world market worth $1 trillion per annum – and the moral and human costs of people not having access to medicines, make this a problematic and highly charged area for GHG. Problems of resource allocation, differentiated market structures, national procurement, quality and quality assurance guarantees, regulation and registration all constitute further factors that restrict global access to medicines. Moreover, the problem is accentuated in relation to neglected diseases and the 90/10 gap whereby markets fail to facilitate access to medicines when people are too poor to create the necessary demand to stimulate drug innovation. It was also noted that governance of this particular issue area tends not to be overseen exclusively by health-related actors, but involves other institutions and agencies associated with global production and trade.

Dr Williams then outlined the crucial role played by two powerful regimes in the global governance of access to medicines: the IPR/trade regime and the 'Pro-Access' regime. Understanding how and why these regimes interact has been a main focus of his research.

The IPR/trade regime is dominated by the need to intervene in the market to incentivize innovation. Crucially however, under normal economic conditions, if knowledge-intensive goods such as medicines are not protected from copying (as with generics) by patents, then there is very little incentive for further innovation and development. This basic problem led to governance instruments to intervene in the market to prevent the problem of 'free-riding' by the development of incentives such as temporary monopoly rights and other exclusivities maintained under IPR laws. The best known of these instruments at the international level is TRIPS – the Agreement on Trade-Related Aspects of Intellectual Property Rights – which itself was originally shaped and justified by means of a number of basic economic assumptions

that have been associated with patent systems over a long period of time. However, more recently, such a patent system has come under increasing criticism due to the negative impact on access to medicines globally, and because it fails to function in terms of the very economic rationales that supported its contentious application to drugs.

Other ways of looking at the access to medicines case in GHG have emerged to challenge the IPR/trade regime, most notably in terms of the idea of human rights and that of development (as seen in the South African legal dispute of 1999-2001 and the WTO Doha Declaration of 2001, for example).

What can be described as a 'Pro-Access' regime involves a raft of new initiatives focusing on product development and research, notable philanthropic foundations in health, and Global Health Partnerships (GHPs) which have developed over the last fifteen years, instigated at least in part by the UN Millennium Development Goals process (MDGs). The activities of these actors encompass new initiatives and funding platforms, and have frequently been couched in fundamentally biomedical terms with the rationale for their for their formation often a response to specific disease(s). Ostensibly, rather than focusing on economics, markets, commercial interests and patents, this regime is closely linked with development assistance and humanitarian action. Despite these preoccupations the pro-access regime necessarily still needs to operate within the overarching context of a dysfunctional pharmaceutical market. They are therefore, and despite the manner in which their role in GHG has been presented, market-intervention actors. Indeed, their engagement with the dysfunctional market involves intervention in two principal ways: firstly on the price of drugs, and secondly in order to stimulate innovation.

So-called health financing organizations such as the Global Fund and GAVI provide significant amounts of funding to recipient countries, facilitating access to medicines through purchasing both generics and innovator drugs. Other interventions on price include tiered or differential pricing initiatives (for example AAI); donation programmes (including those by Pfizer and Merck etc); pooled procurement initiatives (for example: UNICEF, and the Global Fund's new Voluntary Pooled Procurement scheme); and negotiated price strategies (including the Clinton Foundation and UNITAID). Interventions on innovation have been characterized by a raft of new product development partnerships, associated particularly with the partnership brokerage role of the Rockefeller and Gates Foundations (with the latter organization also being a key donor). More generally, interventions on innovations can be captured in terms of providing either push or pull mechanisms for innovation. The former

are often focused on up-front grant-making at the start point of product development and research. Grants are used to stimulate research and development in areas with otherwise insufficient economic demand, as is the case with many neglected diseases (thus the Gates Foundation funds some 60% of the Program for Alternative Technology, for example).

The pull mechanism seeks to stimulate medical R&D by supplying rewards for innovation, at the end point of the product development cycle. The most notable example of a pull mechanism is the Advanced Market Commitment for the pneumococcal vaccine. More recently there have been more radical suggestions for new medical innovation reward schemes, such as Health Impact Funds and prizes. In these instances, there is an increasing sense that many of the proposed alternatives to patents are serving to reframe the basic problems of access to medicines in quintessentially economic terms, and are using economic ideas to undermine the very economic assumptions that have justified and framed the global patent system.

In conclusion, there are linkages between the two regimes. Dr Williams asked whether the pro-access regime had given new legs and legitimacy to the IPR/trade regime. While gains have been made in securing wider access to certain medicines, is it the case that it was 'business as usual' in the wider political economy of pharmaceuticals, and that piecemeal interventions on select disease needs have refocused attention away from the IPR/trade regime at a time when it appeared to be facing a crisis? Crucially, the IPR/trade regime is still the only current 'systemic' global structure for pharmaceutical innovation and the economic framing of patents has proven particularly durable in the face of sustained opposition and counter-framing, Indeed, despite being directly challenged by competing ideas such as the human right to access medicines, and by policy developments such as the WTO Doha Declaration, the economic ideas supporting patents on drugs has found new vigour and has informed new sites of governance.

Dr Williams offered a number of recommendations for the future of the issue of access to medicines:

1. Clarification of the laws on compulsory licensing and parallel importation.
2. Improving standards for patentable subject matter in health, led by WHO.
3. Develop rigorous international competition laws for health and life sciences.

    4. Develop and support new international treaties on research and development, and pilot new incentive mechanisms.

Professor Kelley Lee opened by noting that tobacco control makes an interesting case because it is able to illustrate both the successes and failures of GHG over the last two decades.

The historical background of tobacco control might be regarded as illustrative of weaknesses of the GHG regime. Prior to the 1990s, a degree of tobacco control might be termed 'international' but was focused mainly on states and government-level regulation and was relatively weak in its development. The WHO Tobacco and Health Unit had very few staff and limited resources and its activities mainly centred on collecting data from member states. Most work on tobacco control came at the national level and most in high-income countries (there was less progress in low- and middle-income countries). There was a gradual change in policy over time with a corresponding rise in tobacco control policies and legislation including restrictions on advertising and on sales to minors, for example. However, progress was slowed by tobacco industry success at protecting its interests through lobbying, advocating for voluntary codes, undermining public health advocates and shifting their targeted markets from high- to middle- and low-income countries. This period also saw the rise in active campaigning by civil society groups, mainly in high-income countries, including ASH, the American Cancer Society and public health advocates more generally.

Professor Lee went on to note that it was not until 1998 that real progress was made in global tobacco control with the election of Gro Harlem Bruntland as WHO Director-General. Brundtland's new cabinet recognized that tobacco control was a neglected issue with the potential for significant improvements in health globally. As a result, it became one of two cabinet priorities (along with Roll Back Malaria). While the resolution to adopt the Framework Convention on Tobacco Control (FCTC) had been adopted by the WHA in 1996, there had been no action to take this forward. As part of Bruntland's restructuring of the WHO into clusters, the Tobacco-Free Initiative (TFI) was created and located within the Non-Communicable Diseases (NCDs) cluster, led by Derek Yach, with direct reporting back to the Director-General. However, TFI and WHO still faced an uphill battle. The evoking of treaty-making powers (WHO Constitution, Article 19) had not been done before and there had been a long history of neglect of the area of tobacco control more generally by member states, the WHO and the donor community, all of whom had prioritized other health issues. Perhaps unsurprisingly, immediate, strong

and ongoing opposition by tobacco industry (and some governments) also emerged. The tobacco industry attempted to cast doubt on the validity of the evidence on the links between smoking and ill-health, couch restrictions on tobacco use as an infringement of people's human rights and suggested that it was in fact an economic rather than a health issue, and thus supposedly beyond WHO's remit.

From a wider project perspective, one might expect that tobacco control should have been most easily framed within the issue area of evidence-based medicine. WHO's tobacco control measures focused on presenting the decades of evidence of the links between tobacco and disease, but it was recognized that this had to be done in a different way to gain greater policy leverage and in order to counter the industry's extensive undermining of the evidence base through front groups, paid consultants and 'junk science'. Furthermore, the new approach aimed at overcoming political apathy, beginning with publicizing stark numbers of tobacco morbidity and mortality through presenting and re-presenting evidence in slightly different ways. For example, 'headline statistics' were developed such as millions of deaths annually, projections of 8 million deaths by 2030, deaths per second and the equivalence to x number of plane crashes, in order to increase the impact of evidence. In addition, tobacco use was specifically presented as a disease rather than a lifestyle choice, which had hitherto been the dominant perspective, leading to an emphasis on behavioural change or arguments that smoking-related diseases are 'self-inflicted' Moreover, tobacco control was framed as a *global* disease issue akin to the HIV/AIDS pandemic.

It was also realized that tobacco control measures needed to be 'measurable' in order to appeal to donors and governments. As such, tobacco control could be usefully conceived as a part of a 'package of interventions', somewhat similarly to the 1993 World Bank Development report. A specific type of language began to emerge as a way of quantifying the problem of tobacco use – 'vector', 'pandemic' and 'infection' were frequently used, for example. In recent years this has led to the creation of the TFI's MPower package of policy priorities and measures to implement the FCTC. In addition, TFI has supported the establishment of 'comprehensive information systems for tobacco' (including the Global Youth Tobacco Survey for example) to improve the evidence base on tobacco use. All of this had strategic value, appealing to donors such as Bloomberg and the Gates Foundation who were more willing to support 'evidence-based interventions'.

The economic frame has been a key part of the tobacco control story, initially used mainly by the tobacco industry. The latter claimed that the tobacco

sector created net economic benefits to society and should be treated favourably by governments; that smokers subsidize healthcare systems through taxes; and that the tobacco sector creates employment. By the late 1990s, there was recognition that these politically influential arguments needed to be challenged and countered. Public health advocates thus mobilized arguments that tobacco taxation was the most effective measure that governments could take; that taxation was a 'win-win' by increasing government revenue and reduce demand especially among youth; that smokers use a disproportionate share of health care; and that tobacco diverts economic resources from other sectors (including food). In 1999 the World Bank published *Curbing the Epidemic,* a seminal report bringing together already-existing data but repackaging it and creating a catalyst for further action on tobacco control. This was also a period of unprecedented attention to health economics (for example, the WHO Commission on Macroeconomics and Health). In addition, the TFI created a Tobacco Control Economics Team in 2007.

The security framework is also useful in relation to the case of tobacco control, although arguably in a less obvious manner than the two already discussed. The examination of tobacco control through a security frame focuses on smuggling and its relationship to terrorism and organized crime. The issue of smuggling has been prioritized by member states in terms of making it the subject of the first (and only) protocol of the FCTC. However, it is questionable how much priority it has been given due to the length of time the process has taken: the FCTC was signed in 2003 but the draft text of a Protocol to eliminate illicit trade in tobacco products was not agreed until April 2012. There has been resistance by industry to the role played by WHO, citing it as 'counterproductive' and suggesting the issue was already 'dealt with through existing structures'. Nevertheless, WHO sought the involvement of law enforcement bodies and customs officials, perhaps recognizing that the security frame helped the protocol negotiation process. Interestingly for the wider project, it is also possible to conceive of the security frame being combined with the economic frame to gain additional policy leverage in relation to lost tax revenues through smuggling, for example.

The human rights frame has not been prominent, and is generally observed as centred on industry use of libertarian arguments to defend smoking as individual choice or right that should not be interfered with by state regulation. Aware of the effective use of this argument provoking fears of a 'nanny state', the public health community has reframed the argument through advocating right of non-smokers (especially women and children) not to be exposed to

secondhand smoke; showing smoking to be an addiction rather than a choice; and exposing the funding of smokers' rights groups by the tobacco industry.

Finally, there has also been tension between the tobacco industry and public health advocates in relation to the fifth and final frame – development. The industry has argued that tobacco is a legal product that generates important revenues for developing countries; that tobacco farmers depend on the industry for livelihoods, and that global tobacco control is a form of colonialism where Western countries tell developing countries what is in their best interest. All of these claims are disputed by tobacco control advocates by highlighting the non-productive sectoral nature of the tobacco industry, along with exploitation of tobacco farmers and their exposure to harmful work (through exposure to chemicals for example) and the use of child labour. More generally, collective action to address the transnational nature of the problem – rather than developing countries simply being dictated to by Western states – is also emphasized.

In conclusion, Professor Lee noted that right from the outset, tobacco control has been a political battle against powerful vested interests that framed tobacco use in certain ways and it was only when public health advocates reframed key issues that weak national/international tobacco control was transformed into global tobacco control governance. In relation to the wider project conclusions, the global governance of tobacco control reflects the strengths and limitations of (re)framing. Furthermore, the effective use of framing requires strategic approach that takes into account prevailing public opinion, broader public policy debates and timing. Different frames worked at different times and not all equally effective. The strategic use of frames needs to be included as a core part of the necessary process of building global health governance.

*In the **discussion**, points made included the following:*

- That there is a difference between 'global health governance' and 'global governance for health'. Although the terminology is problematic, the term GHG depicts a governance that is more internal to health.

- That there are factors other than ideas (including institutional development, leadership, timings, contexts, and power relations, for example) that shape GHG. In this project we were fully aware of the role of contexts in framing and reframing ideas. For example, this was seen in relation to tobacco control prior to the FCTC. WHO was in institutional crisis and to a degree the

emerging policy on tobacco control became a symbol of the reinvigoration of WHO as a global institution. This was also linked to the ongoing impact of the end of the Cold War with the associated rethinking of security concerns, for example. Overall therefore, the timing was right, institutional leadership was revitalised, the evidence was there but the agency was required to give the extra 'push'.

- That metrics are widely used as a tool to support different visions of health and health policy solutions and as such as not value-neutral.

- That all of the frames examined in the project can be clearly seen in the horizontal-vertical debate (i.e. the debate between those who prioritize health through a systems lens and those who prioritize individual health problems). The frames have played a part in influencing policy outcomes, not least in relation to the dominance of vertical approaches in recent years.

- That the debate on GHG is largely generated by Northern /Western states, but there are nevertheless indications in arenas such as the negotiations on the FCTC that low- to middle-income countries can both support GHG initiatives and use frames to promote them. In this respect the project's focus on ideas reveals how less powerful actors can influence outcomes in GHG.

- That patents play a critically important role in innovation because they have been presented as the only viable mechanism for incentivizing research and development. In particular, the economic frame that justifies patents on drugs has therefore proven very powerful, durable and resistant to counter-framings.

- That although technological innovation is a key element in improving health, uses of technology are informed by visions and ideas of health.

Session Two: Pandemic Influenza, HIV/AIDS and Conclusions

Presentations: **Adam Kamradt-Scott**, *Senior Lecturer, Centre for International Security Studies, University of Sydney*; **Simon Rushton**, *Research Fellow, CHAIR, Aberystwyth University and Associate Fellow,*

Centre on Global Health Security, Chatham House; **Anne Roemer-Mahler**, *Research Fellow, LSHTM; Research Fellow, Centre on Global Health Security, Chatham House*

Chair: **Kelley Lee**

Dr Adam Kamradt-Scott opened by explaining that at the start of the project (early 2009) the main focus of issues pertaining to pandemic influenza was bird flu (H5N1) but this was almost immediately overshadowed by the swine flu (H1N1) outbreak of that spring. It was noted that technical cooperation structures in the area of influenza were well established, and became embedded within the WHO structure very soon after the organization was founded. Since then the network has continued to grow.

The dominant governance ideas seen in the case of pandemic influenza over the last two decades have been evidence-based medicine and security. Moreover, these two frames have arguably merged and become increasingly mutually constitutative. The global implications and impacts of the 1997 H5N1 outbreak in Hong Kong, the emergence of the same strain in Asia and the Middle East from 2003 onwards, and the 2009 H1N1 outbreak have helped to reinforce the significance and power of pandemic influenza. However, it was noted that the case of pandemic influenza is rarely framed within the context of the idea of human rights, with the exception of limited discussion of civil liberties in relation to quarantine and isolation practices or compulsory vaccination and the 2011 preparedness framework. Similarly, the economic frame is arguably only reflective of heightened security implications, for example.

The actors also differ – in the case of pandemic influenza these remain firmly grounded at the level of the state. Within this context a prominent role has been played by the medical policy community, and key actors in elevating the threat have included such individuals as Robert Webster, Michael T. Osterholm, and Anthony Fauci. In contrast to other case studies, there has been comparatively little civil society or community level organizational involvement. The governance of pandemic influenza has mainly been conducted between governments or in international organizations. It has also witnessed the creation of a supra-international organization in the form of UNSIC headed by David Nabarro as the Coordinator.

The governance structures advocated by these actors can be broadly defined as either pharmaceutical or non-pharmaceutical control measures. The former are drug-based therapeutic treatments designed to either convey a

level of immunity to, or reduce the symptoms of, pandemic influenza (i.e. vaccines and antiviral medications respectively).

Since the late 1950s, vaccine development and administration has remained the cornerstone of pandemic influenza preparedness, backed up in more recent times by the rise of antivirals as a 'second tier' of defence if and when vaccines are unavailable. Overall, there has been a fixation on pharmaceutical interventions and non-pharmaceutical measures (such as social distancing and hand-washing) have generally been overlooked. Since 2005 there has been a drive to increase global manufacturing capacity to counter pandemic influenza outbreaks. However, the 2003- H5N1 outbreak also served to highlight to paucity of existing influenza surveillance and response mechanisms particularly within and between more vulnerable areas of the world often considered to be at highest risk. Between 2005 and 2009 there was a drive to increase pharmaceutical manufacturing capacity but concerns remain over supply and distribution capabilities.

What are the implications of this for the global governance of pandemic influenza? Firstly, health system strengthening is necessary across the board, including in high-income countries. Secondly, as 85% of the world's population would not have early access to vaccines, building the 'evidence-base' for non-pharmaceutical measures has to be a priority. Thirdly, global vaccine production capacity needs to be increased alongside research into the feasibility, appropriateness and efficacy of other drug-based treatments (such as statins) in pandemic influenza outbreaks. To achieve this, the application of other frames such as human rights may assist in re-shaping the agenda and securing additional resources needed.

In his introductory remarks, **Dr Simon Rushton** noted that the global governance of AIDS has been one of the main focuses of attention within global health governance more widely, with an unprecedented level of financial investment, not least from the US and some of the other major G8 donors. However, the results of this massive investment have been mixed – while around 7 million people now receive antiretroviral therapy (ART), compared to about 300,000 a decade ago, this means that only around half of people who need treatment are actually receiving it.

Dr Rushton then explained that AIDS has also been one of the health issues within which   we have seen significant institutional changes at the global level, from the creation of UNAIDS in 1996, to the innovative mechanisms such as the Global Fund and IAVI. In terms of occupying a complex global governance architecture, with multiple institutions with overlapping mandates

being – to some extent at least – in competition for resources and for leadership, AIDS is a classic case. Furthermore, this complexity of actors also plays out at the domestic level within aid recipient countries. Overall, AIDS is a case that speaks to many of the bigger themes and issues that have been discussed around global health governance more generally – about complexity in the institutional architecture; unmet resource needs; the appropriate weighting of priority between different global health challenges; and about the need for effective leadership.

In terms of the project as a whole, at the 'macro-level', the different ideas being looked at in the project have fundamentally shaped what kind of problem AIDS is considered to be, and also possible national and global responses. Indeed, the very idea that a 'global governance' of AIDS is needed, rather than governments addressing it individually at the national level, is itself the result of a particular set of ideas and beliefs about the nature of the problem and how it needs to be addressed.

During the 1980s, thinking on AIDS emphasized aspects of evidence-based medicine: firstly, understanding the causes of AIDS and the nature of the virus; secondly, concerted efforts to find out more about the epidemiology; and thirdly efforts to find an effective response, on both the prevention and treatment sides of the equation.

But at the same time, ideas of human rights were very much in evidence, as affected communities and their allies attempted to combat the stigma and discrimination encountered by people living with HIV and AIDS.

As the epidemics in the developing world – particularly in sub-Saharan Africa – gathered pace AIDS was increasingly labelled as a development problem, a change that was undoubtedly helped by the increasing 'normalization' of AIDS in the West. The development problem had causality in both directions: high levels of HIV incidence seemed to be associated with poverty and underdevelopment. At the same time, the massive human, social and economic costs of HIV and AIDS undermined the prospects for *economic* development. Thus the argument for a 'vicious circle' around AIDS and development – and the need to turn this into a virtuous circle – became established, and remains highly influential to this day.

The security framework has also been in evidence at various points in time – from the discourse around AIDS as a threat to human security in the 1990s, to the discussion about AIDS as a threat to state security and stability in the early 2000s. And this represents a very different view of the 'AIDS problem', and perhaps a different set of priorities that need addressing.

Some of these shifts in ideas have come about as a result of material changes – the rapid spread of HIV in sub-Saharan Africa, for example; or the invention of antiretroviral drugs (ARVs) in the late 1990s that transformed the range of possible policy options (furthered by the entry of generics in the early 2000s). But elsewhere, ideas informing policy have evolved as a result of agency – of people and organizations promoting particular ways of thinking about HIV and AIDS and particular ways of acting.

A number of problems in taking this type of a macro-level view of GHG and AIDS were then outlined. Firstly, it was emphasized that viewing the AIDS case in such a neat, linear story of biomedicine, to rights, to development imparts a false narrative in what has been a far more complicated story. It tends to suggest that the global governance of AIDS is something that can be turned into a neat story of 'progress'. Secondly, it tends to suggest the idea that it is possible to speak of a single 'global governance of AIDS' that at any one time has operated according to a coherent unifying logic. In fact, the 'governance' of AIDS is much more diffuse. It happens at various levels – from the hyper-local up to the level of the big global institutions, all of which have different modes of operation and different worldviews.

In addition, it was suggested that there is no one thing being 'governed' – in fact there is an array of different issues which are embedded within consideration of the AIDS case, including changing individual behaviour, delivering drugs, strengthening health systems and vaccine research. Within each of these areas there are ongoing debates over appropriate policy responses – debates that are each fundamentally informed by the kinds of ideas we're looking at here. Consequently, the interaction of policy debates and ideas has also been examined, including for example: debates around travel restrictions on people living with HIV; debates over compulsory HIV testing, and wider debates over the balance between a vertical AIDS-focussed response and efforts to strengthen health systems more generally.

Crucially, all of the ideas being looked at – and others – have been in evidence in debates around AIDS. Indeed, out of the different health issues that have been examined, AIDS is in many ways the one that has had the most different ideas in play. Partly because AIDS is a multidimensional problem which lends itself to being framed in different ways, but probably also a result of the intensely political nature of the global response.

There is considerable evidence of particular ideas being used deliberately and strategically in the pursuit of particular policy aims. The promotion of the idea that AIDS poses a threat to international security – an argument most

prominently endorsed by the UN Security Council in 2000 – is one of the clearest examples of a deliberate attempt to raise AIDS' profile on international political agendas by framing it in new ways and presenting it through the lens of some quite different ideas. Arguments around human rights have also been extremely prominent (including in debates over harm reduction and access to ARVs, for example). Unsurprisingly, these different ideas have influenced policy choices; they have also been traded-off against one another. In the travel restrictions debate, for example, there was essentially a face-off between the proponents of restrictions, who generally portrayed them in terms of economics and security – the economic cost of treatment and care for HIV-positive immigrants and the public health protection of the domestic population against the supposed 'threat' of people living with HIV – against a determined campaign to argue against travel restrictions on the grounds of rights, as well as to disprove the economic and security arguments put forward in favour of them.

The importance of this was emphasized because all of the ideas being looked at in the project are things which, in the abstract at least, seem like 'good things' that most people would sign up to. But in practice it isn't always possible to have them all, and political choices need to be made. There is also, of course, plenty of evidence of power being decisive, although importantly not always in negative ways. Indeed, the recent prioritization of AIDS in global health governance has to a great extent been the result of powerful states treating it as a priority. But there are also some interesting findings about the ways in which the interests of the most powerful states in the international system have been shaped by ideas – and evidence that the deployment of particular ideas, by particular actors, in particular ways can have profound effects upon the policy of the powerful. The travel restrictions case (with the recent change of policy by the US) is one example.

It was also noted, however, that it is necessary to consider the extent to which AIDS might be deemed unique, or whether it is essentially the same as other health issues.

Firstly, the kind of activism and advocacy that we've seen around AIDS hasn't really been seen around many (if any) other health issues. And it isn't easily replicable, because this is so tied up with the history of the disease, the communities in which it was first identified, and the ongoing hard work of activists over the last 30 years to fight for AIDS' place on the agenda. These groups have had notable success in engaging powerful actors, and progress (albeit it not enough) has flowed from this.

One of the things that may be applicable elsewhere, however, is the role of smart advocacy in the framing and reframing of AIDS: about speaking different languages to engage the interests of different policy audiences and about strategically using ideas and values which are hard to argue against.

And here, finally, the prominence of ideas of human rights around AIDS has been crucial in many ways, and in many debates. Arguing for the human rights of those affected by HIV and AIDS – and calling policy-makers out on the human wrongs inflicted – has been one of the most interesting and important features of debates around AIDS. And in many of those debates, rights have triumphed over other ways of thinking (economics or security, for example).

In her introductory comments, **Dr Anne Roemer-Mahler** emphasized that the macro-level conclusions are still at a relatively early stage but that that there are currently three key points which have emerged out of the project.

1. While not a 'new' conclusion per se, the project has reinforced the influence of politics in the development of GHG. As such, politics has shaped the governance agenda, helping to identify which issues and ideas are considered important at any given time and what policy solutions are proposed to address them.
2. It was noted that most people looking at the politics of GHG have focused on interests and power relations, but that this project is able to demonstrate that ideas are as integral to the political process.
3. No single coherent idea has driven the development of GHG so far. Rather, in all the cases, there are competing frames that have ebbed and flowed over time – different ideas compete for influence in GHG.

Recognizing the importance of ideas and the competition between ideas is therefore crucial. However, thinking about implications of the project for global health governance requires a step from thinking about ideas to thinking about institutions. It is widely recognized that global health is a multi-sectoral issue. The project has also demonstrated that this is the case not only with regard to determinants of health and influencing health policy, but also with regard to ideas shaping how we think about GHG. We think about health as an issue of trade, security, development and the environment, for example. The multi-sectoral nature of the issue offers great opportunities for cooperation and therefore governance. Integrating health into the governance of other sectors could serve to raise the profile of health alongside other global issues, and potentially also increases access to resources for health.

However, there is likely to be a trade-off here whereby integration of health into the governance of other sectors needs to be balanced against the potential for subordination of health concerns to other policy concerns, such as trade and development, for example. Furthermore, integrating health governance into other sectors bears the potential for coherence on global health policy to be compromised.

How might it be possible to both reap the benefits of multi-sectoral governance on the one hand, while also avoiding the subordination of health vis-à-vis other policy concerns on the other? One possibility is a strong institution that takes the lead in GHG. Such an institution might make valuable contributions on two levels. Firstly, it might critically engage with the evidence put forward in support of the various ideas and frames. Such a role is valuable because the project has highlighted that the ideas and frames are rarely self-evident: in fact, links between health and other areas are frequently both complex and ambiguous. Secondly it could actively promote multi-sectoral governance. By taking an active role in the process of integrating health concerns into the governance of other sectors it could raise the profile of health issues and help create coherence within global health governance.

*In the **discussion**, points made included the following:*

- That health policy-making is always political, but the process is often given the veneer of being apolitical by the use of approaches such as cost-effectiveness and evidence-based policy. As with metrics, these are not neutral but are used to validate different visions.

- That the existence of multiple visions of global health has created a complex landscape for GHG. The need to balance coherent policy-making in a globalized world with an increased plurality of interests, visions and actors (including the emergence of BRICS) creates potentially unresolvable tensions. The solution of a single lead body (such as WHO) to promote global health is desirable to some but contested by others who see pluralism as either unavoidable or desirable.

- That the complexity of the landscape creates challenges for leadership in GHG. At present there is no single coherent leadership or vision in global health, but rather a plurality of actors articulating different and competing visions with no harmonizing dynamic. The challenge of leadership therefore is one of consensus building rather than exercising authority. A

number of delegates identified the UN system as a potential vehicle for consensus-building given its recent engagement with health issues such as HIV/AIDS and non-communicable diseases.

- That visions of GHG are translated into material action through frames establishing what is and is not possible and desirable. At the most basic level, that action is not possible without having ideas.

Thanks were expressed to Chatham House, the European Research Council and the BISA Working Group on Global Health and particularly to the audience for their involvement and challenging questions.