Understanding *Global Health Governance*: A Review of Jeremy Youde’s Book

Jeremy Youde (2012) Polity Press, 240 pp; ISBN: 978-0-7456-5309-9

*International Politics Reviews* (2014) 2, 87–99. doi:10.1057/ipr.2014.14; published online 14 August 2014

A comprehensive reference for policymakers and scholars

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If you are looking for a comprehensive overview of the history and key actors involved in addressing global health issues, then Jeremy Youde’s book *Global Health Governance* provides an authoritative survey. Youde documents the initial origins of the field as it emerged from concern about infectious diseases and the potential impact on trade from overly restrictive quarantine measures. He captures the important post-World War II rise of the World Health Organization (WHO) as the central agency tasked to deal with international health issues. He covers its success in smallpox eradication and the organization’s gradual decline as its core budget remained flat and other actors such as the Global Fund and the Gates Foundation emerged.

I assigned the first six chapters of Youde’s book for my graduate course this past spring, and for those who need to be brought up to speed in a hurry on the major actors in global health, Youde’s book is a tremendous contribution. The three final substantive chapters cover an eclectic set of substantive issues in global health, surveillance in global health and the International Health Regulations, the risks of framing health issues as security threats, and access to pharmaceuticals, focusing on AIDS drugs.

**The Scope for Cooperation in Global Health**

In the interest of a friendly critique, if Youde is to write a second edition, I would counsel a stronger connection to debates in international relations about cooperation and the efficacy of international organizations. For example, more could be said about the issue area and the scope for cooperation in global health based on the simple fact that actors have a shared interest most of the time in achieving good health outcomes. Unlike other areas, such as environmental protection or security, where actors’ interests are often in conflict with each other, most global health issues are ones where states have strong incentives to cooperate, particularly when leadership is provided to overcome collective action problems.
Here, some of Todd Sandler and Scott Barrett’s work on global health and the political economy of disease eradication could be quite useful. I think this is one powerful reason why the history of global health is actually quite positive from the perspective of eliciting cooperation from states. Still, even for smallpox, as Barrett’s work has demonstrated, states nearly failed to come together to raise the small amounts of money that were ultimately needed to eradicate the disease.

Do International Organizations Matter?
At the same time, Youde would be well-served by picking up the theme in international relations on whether and when international organizations like the WHO have independent power of their own and why states would delegate authority to them. What are the essential functions that only the WHO can provide? This question is both important from a theoretical perspective but also a practical one as the organization struggles to find a mission in a more complex organizational landscape and an era of heightened competition for funds in the global health space.

In the substantive chapters, I also see some scope for revision, in part to take advantage of events. Youde writes ably about the updates over time to the International Health Regulations, particularly in the wake of the SARS outbreak in 2003 during which China was slow to report cases of the new disease. During this episode, WHO took advantage of ambiguity in its authority to issue a travel warning. The SARS episode also prompted a revision in the International Health Regulations in 2007 that had become out of date and covered only a few illnesses like yellow fever, which were less pressing than they once had been.

The question that comes out of this is whether the WHO’s authority has been enhanced by changes in the regulations that allowed it to declare a global health emergency, something the organization has done twice since 2007, most recently with the polio outbreak that emerged in 2014. With the regulations set to be revised again this year, this question too is an important one for scholars and practitioners.

Health and Security
In his chapter on efforts to frame avian flu as a security threat, Youde echoes an argument that Daniel Deudney made in a 1990 article on environmental security in Millennium. As both Deudney and Youde argue, while framing the environment or health as security threats has the advantage of jumping issues up the queue of attention in policy circles, it potentially comes at a cost. Such a security frame enables governments to pursue extraordinary emergency policies, potentially setting aside normal procedures and also elevating the role of the military in ways that may lead to, as Youde suggests, ‘inappropriate responses’.

For precisely these reasons, Youde critiques the US government for securitizing avian flu in the early 2000s. However, it is a bit unclear if rhetorical efforts to securitize avian flu, beyond the potential for excessive spending on the issue, were matched by policy action. Indeed, if we look beyond avian flu to other flu pandemics that emerged in the 2000s, US policy appears to have been more measured. In his 2010 report comparing Chinese and US responses with the later H1N1 swine flu epidemic, Yanzhong Huang argues that the Chinese, not the United States, adopted a draconian and ineffective policy that tried to quarantine those suffering from H1N1. Such a policy has much more in common with the emergency securitized approach that Youde critiques. The US approach to swine flu was much more measured relying on early diagnosis and treatment, recognizing that it was too late to quarantine.

Youde’s chapter builds on previous work he’s developed in article length on avian flu, but the book chapter could benefit from a slightly wider aperture on other flu epidemics, particularly as new ones have emerged such as the Middle East Respiratory Syndrome and other threats like bird flu and Ebola have re-emerged. Given the repeated emergence of flu epidemics that potentially could kill larger numbers but have not yet, what is the right balance in attention and spending for these health care threats, particularly as we do not really know how transmissible or lethal they are likely to be until after the outbreak has started?

Access to Medicines
Youde’s final substantive chapter is called ‘Access to Pharmaceuticals’, but it really is focused on the extension of drug treatment access for HIV/AIDS. This is certainly an important topic, as I have a whole book dedicated to this theme, but in a wider treatment of global health, there are two lacunae that Youde could address in a revision. The chapter itself picks up the story of access to antiretroviral drugs (ARVs) in 2003 when the WHO and UNAIDS set a goal for extending access to 3 million people by 2005 (the so-called 3 by 5 initiative).

The focus on the 3 by 5 initiative was a little curious for a few reasons. First, the Global Fund and PEPFAR, the US bilateral AIDS program, were far and away the most important funding agencies that extended access to antiretroviral drugs. The 3 by 5 effort was an important but time-limited exercise that followed the creation of the Global Fund. Since the WHO was not a funding agency, the campaign was mostly about focusing attention and agenda-setting, but the true success on that score had already been achieved by then UN Secretary General Kofi Annan in 2000 with his call for the creation of a global
fund to fight AIDS and finance treatment. Even among WHO- and UNAIDS-led agenda-setting activities, the 3 by 5 initiative was one among several efforts that then UNAIDS director Peter Piot was involved in. His personal role, captured in his 2013 memoir *No Time to Lose*, might be more important than the institutional legacy of 3 by 5.

The other key point to mention is that the emphasis on the provision of ARVs also should talk about intellectual property rights and the fights over access led by Brazil, South Africa and NGOs such as Doctor Without Borders in national courts and in international venues like the 2001 Doha trade negotiations. This is a huge and important part of the story that Susan Sell and Aseem Prakash, among others, have written about. When I read the chapter title, I initially thought that it would focus heavily on intellectual property rights and the fight over drug access, which historically has mostly been about HIV/AIDS drugs but is increasingly about pharmaceutical access to fight other diseases such as cancer and hepatitis. That story, about free trade agreements, patents and push back by states and civil society to extend access is on-going and an important part of debates linked to pending initiatives like the Trans-Pacific Partnership and the EU–India bilateral trade deal. While Youde discusses the topic in his chapter on civil society organizations, it is a core part of the story in ARV access.

**Non-Communicable Diseases (NCDs) and Health System Capacity**

Access to medicines is also hugely relevant now as health campaigners have increasingly turned their attention to NCDs such as diabetes and cancer. Youde acknowledges that most of the book is focused on infectious disease, and rightly so, as the field itself has a strong emphasis on infectious disease. That said, there may be scope in an updated edition to discuss the emergent emphasis on NCDs.

More importantly, the book would benefit from a more extended discussion of the critique of vertical disease-specific health interventions that dominate the field and the call for more horizontal investments in health systems capacity. Vertical systems have long dominated global health, and that emphasis has been strong in the turn toward addressing the HIV/AIDS epidemic as well as tuberculosis and malaria that were tied with HIV/AIDS when the Global Fund was created. The call for greater investment in health systems capacity has a longer history, associated with the original push for basic health care embodied in the 1978 Alma Ata Declaration. Youde writes about Alma Ata and the Health for All agenda, but this discussion could have been more firmly situated in the recurrent vertical versus horizontal debate.

**Conclusion**

In sum, Youde’s book is a welcome contribution to the global health governance field. He captures core pieces of the history and landscape of actors in a thorough and accessible manner. With the rise of global health as a more important focus both in policy circles and among scholars, Youde’s book (and updated editions!) will be consulted regularly for years to come.
of the GHG system and discusses some of the political factors that contribute to the current, at times inadequate, system. As the book suggests, the GHG system evolved largely as a response to the threats of commercially important infectious diseases. However, important global health challenges such as the HIV epidemic and the complexities of addressing health issues in an increasingly globalized world have helped to further shape this system. As Youde correctly highlights, the system is still evolving. This book raises some issues that need to be addressed if this system is to remain relevant and to deal with future global health challenges.

The book is organized into three sections. In the first section, Youde provides a historical overview of the origins and early evolution of the GHG system, from its earliest beginnings up until World War II. The author conducted detailed research on this topic and while many texts provide good overviews of this era in global health history, it manages to provide some new perspectives on this topic, including some more nuanced views of the debates that raged at the time among participants.

The second section outlines the main actors that exert power in the GHG system, including the World Health Organization (WHO), the World Bank, select multilateral organizations, private actors as well as civil society organizations. This book aptly highlights the major trends that have happened in the GHG system in the past two decades; the evolution of a system comprised of mainly state actors and traditional intergovernmental institutions to one with a multitude of actors, including a plethora of non-state actors, many of which did not exist much more than a decade ago. The author discusses some of the forces that have driven these changes as well as some of the important consequences of these trends. He critically assesses the current position of the once dominant WHO and concludes that it has lost most of its traditional power. ‘Traditionally, the World Health Organisation (WHO) would be the de facto leader of any such response, but it no longer possesses unquestioned leadership on international health issues’, he writes. He argues that one of the factors that has contributed to the WHO’s decline is that it has taken on too many mandates, from health promotion to health measurement to even providing guidance on how to build and finance health systems.

The World Bank gets its own chapter, which the author calls ‘the most important intergovernmental organization working on global health’, a contentious claim, which perhaps would require further justification. This chapter also provides an excellent historical overview of the World Bank’s work in global health. The author particularly highlights some of the World Bank’s most controversial forays into global health, including its support of the development of the Disability Adjusted Life Year (DALY) and the promotion of the use of cost-effectiveness criteria in global health priority setting. Oddly, arguably the most controversial position of the World Bank in the context of global health, its position on user fees, receives only a passing mention. Even the current World Bank President Jim Yong Kim, has publicly asserted that user fees were a failed policy for the World Bank, one driven by ideology, yet they received little coverage.

Although most reviews of the GHG system will describe the WHO and traditional global health actors, this book gives nearly as much attention to other actors such as the private sector (including, for example, the Bill and Melinda Gates Foundation) and Civil Society Organizations (specifically Oxfam and the Treatment Action Committee) that said, the author’s case selection of institutions might be biased and may limit the inferences that can be made. For example, formidable organizations that have had huge influence in GHG changes such as GAVI and the Institute for Health Metrics and Evaluation are barely mentioned.

In the third and final section, the author further develops some of his main arguments through a series of case studies to demonstrate how the GHG is continuing to be reshaped. For example, Youde argues that the evolution of the GHG system has been a fluid, and largely unplanned exercise, largely responding to threats rather than proactively addressing health concerns. Youde also argues that GHG actors lack a unified vision about the rationale for engaging in global health activities. Initially, the rationale for such a system was rooted in the protection of trade but today GHG actors use human security, economics and equity arguments for continued engagement in global health. Although this multidimensional rationale can be effective at times, it also risks conflict among institutions and weakening of overall effectiveness.

Youde selects three case studies to illustrate his arguments (the global infectious disease surveillance regime, framing of health security and access to pharmaceuticals). All are well researched and interesting; however as before, the case selection argument is not well made. These cases explore relatively narrow changes that have occurred within the GHG system and could have been complemented with more focus on other cases, for example the Framework Convention on Tobacco Control, the rising influence of emerging economies in GHG discussions, or the measurement of health and disease. But what these cases lack in diversity, they more than make up for in depth.

The author’s background as an international relations scholar, rather than a more mainstream public health insider, is both one of the greatest strengths and weaknesses of this book. The book mainly draws on the international relations and political science literatures, a welcome departure from some other texts, many of which have a tendency to build off of publications in medical and public health
journals that can be based more on opinion rather than theory or evidence.

However, the author’s views on disease surveillance, in particular his belief that the global health community has allocated too much attention to avian flu and other infectious disease surveillance activities are controversial. ‘This singular focus on one disease and the possibility that it could at some point evolve to pose the threat of a worldwide epidemic essentially privileges avian flu over other health problems. The problem is not so much that a hierarchy of diseases exists; the problem is that this hierarchy places on top a disease that rarely affects humans’. It is as though the author is arguing that only the burden of disease should be used to determine disease priority. This argument is weak in many ways. First, it would suggest that much more attention should be placed on high-burden diseases, most notably the non-communicable diseases, which receive nearly no attention in this text. Second, it ignores the relatively well-accepted principle in public health that stresses the importance of prevention and preparedness, and the principles of risk and expected tolerance of such threats.

At times, the author also seems to take a lot of evidence at face value without critically examining the evidence of these claims. For example, he argues ‘by creating a primary multilateral source for channeling resources to states in need, the Global Fund has helped add greater efficiency to the foreign aid process’. This is an empirical claim, one that is to this point not well established in the literature (Grépin, 2012). Also ‘the [Global] Fund’s allocation decisions are guided by the “additionality principle” – grants provided by the Global Fund should not subtract from other donors or funding commitments. Instead, Global Fund grants increase the amount of money going to a particular country for work on reducing the effects of these three diseases’. This finding stands in contrast to studies that have suggested that most global health funding is fungible, and the ongoing debate in the literature about these claims (Roodman, 2012; Van de Sijpe, 2013). Although the author eventually admits, ‘It is one thing to proclaim a new approach to addressing global health needs; it is entirely another thing to put that proclamation into practice’. Indeed.

In summary, this book is a thorough and extensive coverage of a relatively challenging literature, one that has been until now less accessible to many in global health, but the book remains highly approachable, to the level that a well-informed undergraduate or masters level student would enjoy, making it a good potential companion to many global health policy or global health politics courses that are currently offered at universities today. It has made the topic of Global Health Governance more approachable and enjoyable to all.

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Making health affairs mainstream in IR scholarship

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Jeremy Youde’s Global Health Governance (GHG) (Polity Press, 2012) deserves to be the standard work on the eponymous topic. It is comprehensive, insightful and lucidly written. Youde has done the fields of global health and international relations (IR) a service with this overview of how the management of health problems and policies has increasingly moved to the international and global level of analysis and how that argument for global governance for the obviously transnational, not acknowledged in all times and places as obvious, has moved from heresy to cliché.
As a subject of consideration for scholars of what Americans subsume under political science and call IR and what the ROW calls international studies and hives off as its own discipline, health affairs has only recently become something that scholars cannot ignore. Ignoring a field of study implies awareness and acknowledgment of its existence. Little more than a decade ago, in American political science at least, such a state of affairs was not the case. As an influential piece from 2001 noted, even 20 years into the AIDS pandemic, with resultant effects as great as war or evolution, ‘political scientists have devoted little attention to the subject’ (Boone and Batsell, 2001). Except for those few who studied it, global health scarcely existed as a subject in political and international studies. On the basis of my own conversations with non-US academics, those who studied global health as politics scholars were deemed sociologists or anthropologists in the eyes of the US establishment.

Today, the state of epistemological affairs is markedly better. Journals like GHG and Global Public Health have come into being; top disciplinary publishers like Cambridge, Oxford and Routledge have put out individual books and even established series on the topic; and the International Studies Association has an organized section on global health. Where a few years ago, attending the biennial International AIDS Conference as a political scientist elicited expressions of befuddlement from the life scientists at the conference, we have moved to a place where big global players like UNAIDS and the International AIDS Society actively solicit and try to integrate the insight of social sciences (see, for example, Altman and Buse, 2012; Paxton, 2012).

While many of the academics who study global health come from outside the United States, particularly from Britain and its former imperial possessions, US researchers have come to the field, often from studying African politics or other sorts of comparative politics. Youde came to global health via studying the HIV denialism of the South African regime under Thabo Mbeki and the countermovement to demand acknowledgment and drugs.

Youde’s book divides into three parts. The first, a single chapter, provides historical context, briefly reviewing the nascent attempts to govern health on the international level; to coordinate actions to protect local, national and regional populations; and to set standards of acceptable modes of conduct in case of epidemic breakout.

The majority of GHG, and the second major part, focuses on the major actors and actor types in the contemporary IR of health. The WHO and the World Bank each receive their own chapters. UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria are considered together. Two further chapters focus on ‘Private actors’ and ‘Civil society organizations’, which devote their attention primarily to the Gates and Clinton Foundations, in the former chapter, and to the whole gamut of CSOs with some special attention to Oxfam and the Treatment Action Campaign (TAC) in the latter. (I must admit that it is not clear to me what constitutes the dividing line between NGO-ish organizations like Clinton/Gates and TAC/Oxfam, as Youde divides them. This is a minor quibble.)

The third section of the book considers some significant contemporary cases of global governance involving the global health issue area. A chapter each considers the 1) International Health Regulations, 2) pharmaceutical access and intellectual property, and 3) the securitization of the content of study and of health politics and policy. This may be the most valuable part of the book for those more interested in global governance over global health; I return to this point later.

I certainly appreciate a need for economy or limits to the overall realm of analytic consideration, but the book would be improved were there a chapter considering the role of the multinational corporation (MNC) in global health’s propagation and governance. This is, to my view, the major weakness of the text. It is not damning, but it constitutes my greatest wish for any possible subsequent edition of the work.

It would be extremely difficult to understated the size and influence of the MNC in global health politics; contrary to expectations, the MNCs involved are not just the members of ‘Big Pharma’ like Merck, Boehringer-Ingeheim, Bayer or GlaxoSmithKline. The quasi-independent charitable foundations that these companies and others spin off have implications for the conduct of local, regional and international policy (Ramiah and Reich, 2005). Beyond pharma, ‘social entrepreneurship’ leverages market mechanisms for private goods to address deficiencies in the supply of public goods. Since the mood of the times is to examine the inequality of wealth and resources within and between countries, understanding and explaining the class of actors with primary importance in transforming resources into capital is paramount.

These players are important because their material resources often dwarf those of other actors in global health. Their ideological and scientific commitments drive the shape of policy responses. Their preference for market-based mechanisms may affect the form of what Lieberman has called the ‘Geneva Consensus’ (Chapter Lieberman, 2009; Altman and Buse, 2012): the standards and practices that organizations like WHO, UNAIDS, the Global Fund and so forth expect countries to adhere to in order to receive technical assistance and funding. Bureaucratic development is a core principle of the Geneva Consensus: governments commit to develop their technical, administrative and management capacities in health and other sectors, so that they can take on the scaled-up programs of treatment, prevention and human rights defense that are at the core of the global HIV response. Bureaucratic
development could also be the component that the MNC might be most ambivalent about; developing management skills among government bureaucrats could either improve or harm a company’s bottom line interests.

Youde might have dedicated more consideration to the ways in which MNCs involve themselves with and influence national and global governance of health. This is not to say that Youde does not address MNCs at all. He explores their role in the controversy around the provision of generic ARVs to developing nations, under the contradictory provisions of the Trade-Related Aspects of Intellectual Property Rights agreement, which both protected intellectual property and incentivized poor(er) countries to abrogate such principles to protect their citizenry.

But there are others examples of these actors in global health:

- The rise of social businesses points out a classic problem in the theory of goods: what sorts of social actors are best providers of public goods, and how much regulation is needed to optimize the provision of club goods and common pool resources. Goods theory shows us that, heresy that it is to say these days, the market is not always the best distribution mechanism for the commodity at hand.

- In the case of GrameenDanone (a social entrepreneurship venture between Muhamed Yunus’s Grameen organizations with the French food conglomerate Danone/Dannon), poor – and generally underemployed – women can purchase containers of a yogurt and then sell these in their neighborhood, making money to meet their own needs. The yogurt is fortified with essential micronutrients that children need, so eating two a day it is one way to ensure better growth and health for them. And even at its quite affordable retail price, the yogurt still makes a profit for GD.

- Given the population-nature of most public health measures, is the atomized, anarchical, individualistic character of a market the optimal mechanism for ensuring the herd’s health? What of those ‘consumers’ who lack the ability to purchase requisite health good? What do we do if there are too high or too low a number of ‘distributors’ (sales staff?) in some area to ensure sufficient coverage with the intervention? These are governance questions, and MNCs are the ones making all the important decisions.2

- Shah (2011) has argued that MNCs, directly or indirectly, distort the global health agenda, through targeted donations. Much of the money – up to 80 per cent, Shah contended – that the WHO has available to it comes from voluntary contributions from private interests, with mining, food and pharmaceutical companies heading the list. The result? Ninety-one per cent of these funds go to diseases that affect 8 per cent of the population.

Readers new to health as a challenge of global governance will likely wonder at the apparently heavy focus on the HIV/AIDS pandemic in the book. ‘What about the other diseases?’ one might wonder. ‘Where are malaria (since Bill Gates wants to eradicate it), cholera (since Haiti acquired it from UN blue helmets after the earthquake) or polio (since it keeps breaking out of Pakistan and Nigeria, most recently causing an epidemic in Syria)’? One might be forgiven for thinking this is a fault of Youde, but it tends to be a fault of the academic study of politics than of this work. As Shiffman et al. (2009) documented, the rising tide of funding for HIV treatment and prevention has not really raised the metaphorical boats of other global health issues. The same has been mostly true in the multidisciplinary social science examining global health issues: most of the extant research, especially on the politics of health, has focused on HIV/AIDS (the situation has improved somewhat since Boone and Batsell’s assessment a dozen years ago). What hasn’t focused on HIV has had to contend primarily with political research on infectious diseases, as these seem to be the ones that get the most attention from governments and other international actors.

What does the book offer for people who don’t study global health? For students and those new to the field, Youde’s overview of actors provides a thorough introduction to the overall structures of global governance in this particular issue area. The third part of the book, with its case studies, will probably prove of most interest to scholars not specifically interested in health but in governance generally or the specific governance of trade law, intellectual property, international security, human rights and sovereignty. The chapter on the IHR shows the articulation and growth of a regime dedicated to an issue of relatively high importance to most states: preventing the introduction and spread of infectious diseases. The most recent revision of the IHR, in 2005, demonstrates an example of institutional learning. The IHR takes our global experience of HIV, SARS and other zoonotic diseases to devise a system that focuses on information sharing and the form of threats, rather than making specific known diseases reportable. I find the chapter on access to pharmaceuticals to be a succinct yet thorough walk-through of the issues involved, including international intellectual property regimes, the relative power dynamics of developing country governments vis-à-vis developed world corporations and their associated governments and the moral implications of what Kapstein and Busby (2010) have called ‘merit goods’.

Fifteen years ago, the governments of the major powers were concerned that epidemic outbreaks in less-developed areas of the world, such as with the AIDS crisis in
sub-Saharan Africa, could destabilize nations of the so-called ‘Global South’, with implications for the countries themselves, as well as for the major powers. At the same time, decision makers and researchers studying global health issues wondered and worried about the positive and negative implications of hitching their wagon to the old warhorse of security studies. Youde covers these debates, in their parallel tracks as well as in their interrelation, well and fully.

Youde’s GHG provides a major contribution to bridging the extant gap between global governance and global health scholars. Both groups will profit from absorbing the ideas and scholarship within this book. Even given the relative lack of attention to MNCs, GHG is the most thorough and clearly written consideration of a topic that will only grow in importance in the coming decade or so.

Notes
1 I heard, ‘Oh. So what are you doing here?’ more than once, as if the idea of academic social science studying HIV/AIDS and the international response was something life scientists and drug manufacturers had not before considered.
2 This is not to say that MNCs shouldn’t be doing this, just that in my view more actors should be involved in making these decisions about populations health interventions.

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Addressing donor—recipient dynamics in global health governance

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At a time when global health governance has become an established field of both policy practice and academic study, Jeremy Youde’s book provides a timely and insightful overview of key players and institutions in the field. Moreover, by situating his analysis in the historical context Youde highlights not only the scale of the changes we have seen in the past 20 years, but also how deeply entrenched some of the problems of global health governance are, especially concerning the role of World Health Organization (WHO) and the issue of leadership in global health governance.

The book does a great job in bringing the changing patterns of global health governance to light. These patterns are made up partly of the shifting constellation of actors involved in global health governance. Youde’s book focuses in particular on WHO and its varying approaches to and role in global health governance, and on some of the new actors involved in global health governance, such as the World Bank, UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, philanthropic organizations and advocacy NGOs. Partly, the changing patterns of global health governance are created by changing ideas about how health issues are to be understood and which solutions are to be pursued. Youde combines an analysis of these ideas and the contestations about them with a wealth of detailed information about the history and functioning of
different organizations. Thus, a picture emerges of a continuously evolving landscape of global health governance with changing groups of players and changing visions for and approaches to global health governance.

A key feature characterizing global health governance today is the proliferation of new and often private actors. Youde’s book discusses some of the most influential ones, notably UNAIDS, the Global Fund, the Bill and Melinda Gates Foundation, the Clinton Health Access Initiative (CHAI), Oxfam and the Treatment Action Campaign (TAC). The book shows how these organizations obtained their role in global health governance against the background of the spiraling HIV/AIDS crisis and the inability of existing multilateral institutions to respond to this threat. It acknowledges the important contributions that these new players have made to global public health, but it also points out that concerns have been voiced about private actors taking on governance functions, and that these organizations have not always had an easy relationship with governmental actors.

The myriad of different types of private actors involved in global health governance today makes it sometimes difficult to categorize them. This difficulty may be a reason for what I feel is a slightly awkward choice of chapter titles. The chapter on philanthropic organizations is titled ‘Private Actors’, while the chapter on Oxfam and TAC is titled ‘Civil Society Organizations’. Yet, civil society organizations are private actors too, and one might even argue that philanthropic organizations are part of civil society given that they advocate for social causes and work on a non-for-profit basis. Furthermore, with regard to the role of private actors in global health governance, a more substantial discussion of the pharmaceutical industry may have been useful. Pharmaceutical companies have become key players in global health governance, particularly in the last two decades, as governments and global health initiatives have promoted the increased availability of drugs and vaccines in a wide range of policy areas, including health, development and security. This trend is manifest in the rise of global financing and procurement organizations, such as GAVI and the Global Fund, public private partnerships to develop drugs and vaccines for neglected diseases, such as DNDi and the Global TB Alliance, pandemic preparedness initiatives, such as the WHO Global Action Plan for Influenza Vaccines (GAP), and anti-bioterrorism measures, such as the US Biomedical Advanced Research and Development Authority (BARDA), which partners with pharmaceutical companies for the development of medical countermeasures. Pharmaceutical companies have become key players in global health governance not only because they produce most of the medicines and vaccines that governments and global health initiatives seek to make available, but also because they often work as partners with these organizations and frequently sit on the governing boards of public–private partnerships. In other words, pharmaceutical companies have taken on governance functions in global health governance and, therefore, are key players not only in the economics but also in the politics of global health.

Jeremy Youde’s book explicitly focuses on the local governance of infectious diseases as these diseases have so far received most political attention and resources. The focus of the book is a great advantage because it allows the author to discuss important actors and policy issues in detail and explore the material and ideological politics surrounding them. It is clearly justified also because the most visible structures of global health governance have developed to fight infectious diseases, notably HIV/AIDS, influenza, malaria, tuberculosis and other emerging and re-emerging infectious diseases. Yet, any focus means that other issues fade into the background. And while focus is necessary, especially when writing a book, I would like to highlight two issues that may help situate the book in wider debates about and developments in global (health) governance.

The first issue I would like to talk about is the book’s focus on the global governance of health in developing countries. Most of the organizations discussed in the book, such as the World Bank, the Global Fund, the Gates Foundation, CHAI, Oxfam and TAC, work on health in developing countries. From this perspective it looks like global health governance was in fact the global governance of health in developing countries. And indeed, most global health governance organizations that have emerged in the past 20 years address health issues in developing countries. Partly, this is the result of their work concentrating on infectious diseases, which are more prevalent in developing countries than in high-income countries. Partly, the focus of global health governance on health in developing countries is the result of a successful framing that has linked health to development. As a consequence, most governments label expenditures for global health as development assistance for health. The implicit focus of the book on the global governance of health in developing countries is therefore a reflection of a focus that has emerged in global health governance in the past 20 years.

Why is this a problem? First, the labeling of governance institutions as ‘global’ that are actually based largely on donor–recipient dynamics creates a tension between rhetoric claim and reality. On the one hand, there is the claim of institutions and policies being global; on the other hand, there is the reality of financing and, therefore, decision making being done largely by a small group of governments and philanthropic organizations based in Europe and North America. Second, a global governance system that is based on donor–recipient dynamics is prone to questions of sustainability. Many donor
governments have accepted that health is key to development and that health threats in developing countries can become a security issue for their own populations. Yet, the rewards for donor governments of investing in health in developing countries are indirect at best, and donor fatigue has become a growing phenomenon. Finally, the current model of global health governance in which a small group of governments and organizations carry most of the costs for health interventions in developing countries is outdated given the economic growth in middle-income countries and the rapidly shifting power relations in the global political economy. These issues shape the politics of global health governance. Making them more explicit may help working toward a system that is substantially ‘global’ and toward governance structures that provide global public goods rather than development assistance for health.

The second issue I would like to raise is the link between global health governance and other areas of global governance. The institutional proliferation in global health governance that Jeremy Youde describes has led to the recognition of health as a distinct area of global governance. Yet, as Youde mentions too, it is now increasingly recognized that health is a multisectoral issue that requires multisectoral governance responses. While a systematic approach to establishing multisectoral governance for global health does not exist, both global public health and global health governance are affected to a considerable extent by the actions and policies of international organizations outside the health field.

Key among them are the World Trade Organization’s agreement on Trade-Related Intellectual Property Rights (TRIPS) and the Doha Declaration on TRIPS and Public Health, as well as bilateral and regional free trade and investment treaties that have emerged since the early 2000s. The agreements establish a range of legally binding requirements for the protection of patents and other intellectual property rights. These, in turn, can shape the prices of medicines and vaccines and thereby their affordability and availability. International trade agreements therefore set a framework of rules within which global health governance has to operate when considering policies to improve access to medical treatment across the globe. In addition, international law enforcement agencies, such as Interpol and the World Customs Organization also shape global health governance. These organizations are involved in the implementation and, to some extent, definition of standards on counterfeit medicines and, thereby, influence an important debate in global health governance, namely how to ensure medicine safety. Global health and the governance thereof is furthermore affected by various environmental treaties. For instance, the Cartagena Protocol on Biosafety on the Convention on Biological Diversity sets norms for the control of imports of genetically modified organisms (GMOs), including on health grounds. The Minamata Convention on Mercury regulates the use and emission of mercury across a range of products, including medical products, but explicitly excludes vaccines where mercury is used as a preservative.

In other words, global health governance has to take into account the norms and rules that have already been established by treaties and regulations in other areas of global governance. Further research on global health governance should therefore include an analysis of how global health governance is shaped by trends and developments in other areas of global governance.

The recognition of health as a distinct area of global governance that requires dedicated resources is an important achievement and, despite some failures, has helped improve the lives of many people, particularly in developing countries. It is therefore important to focus both policy and scholarly efforts on how to improve global governance for health. Yet, in order to better understand how to improve global governance for health we may have to better understand how the global governance of health is operating today. Jeremy Youde’s book makes an important contribution in this endeavor and is rapidly becoming a key resource for scholars and students alike.

The author replies …

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When I was younger, I played cello. My musical prowess did not set the world of classical music on fire, but I enjoyed contributing to the larger efforts of the orchestra and pushing myself to improve my proficiency. My orchestra’s
director would frequently make us record ourselves and then listen back to the results later. That exercise often filled me with dread ahead of time because I worried about the mistakes I would discover (and there were plenty), but it made me a better player. Listening to my playing with my director helped me to identify oversights—hold that rest a bit longer, get that note better in tune, make sure you are in sync with the violas during the coda—that made my future efforts better.

Reading the reviews of my latest book reminded me a bit of my adolescent experience in the orchestra—a bit of trepidation ahead of time, but finding my fears unfounded and profoundly grateful for the experience. Josh, Karen, Nathan and Anne are scholars whose work I have long read and admired, and I particularly value their insights, comments and suggestions. It is as if Zuben Mehta, Yo-Yo Ma, Itzhak Perlman and Gustavo Dudamel were providing feedback on my teenaged renditions of Bach’s Brandenburg Concertos.

Before addressing some of the questions and comments raised by the reviews, I want to discuss a bit about my intentions for the book, situating it within the burgeoning global health politics literature. Over the past decade, we have witnessed the beginning of the emergence of a genuine canon of seminal articles and books, such as Boone and Batsell (2001), Davies (2010), Elbe (2006), Fidler (1998), Lee (2009), McInnes and Rushton (2010) and Price-Smith (2001, 2009), among many others. These pieces have provided a solid foundation for understanding the shifting dynamics within the international community on regulating and reacting to transnational health issues. We have moved from a situation where health languished in the realm of ‘low politics’ (Fidler 2005, p. 180), considered almost entirely a technocratic issue and receiving little attention from international policymakers, to one where governments and the United Nations actively debate whether infectious disease constitutes a threat to national and international security. We have recognized the growing plurality of actors who take an active role in contributing to the international community’s global health responses. We have acknowledged the incredibly political nature of how, when, where and whether coordinated global responses to health concerns will emerge. These are significant advances—both for the global health literature and for the larger international relations literature.

Rules, processes and institutions (both formal and informal) had emerged to govern the global health politics realm. With all of the changes in the issues on the global health agenda, who was involved with it, and how the international community funded it, the time seemed right for a book that could aim to identify all the moving parts that co-existed within this realm of global health governance. In particular, I wanted to write a book that would be accessible to non-specialist audiences, but still be useful to global health politics scholars. Another driving factor was the emergence of a growing number of undergraduate and graduate courses and programs in global health politics. As these courses proliferate, I wanted to write a book that could help students identify some of the key issues, important actors and relevant history in how the current global health governance system evolved. My hope was to help fill a gap and provide a jumping-off point for future research. Underscoring the need for such a book, Sophie Harman and I were working on books on global health governance at the same time and our books came out within a few months of each other. Harman’s (2011) Global Health Governance is a truly excellent introduction to many of the important issues in global health governance, and one that I have used in my own classes. Our books take slightly different analytical foci and highlight different issues, allowing them to complement each other quite nicely.

This sort of strategy necessitated making some trade-offs in the writing process. I could not cover all the topics that could have fallen within the book’s purview. When writing case studies, I opted for depth over breadth in order to provide detailed knowledge and information about a fewer number of issues. I did not engage the international relations literature as intensively as I have in some of my other publications hoping that would make the book useful to both political science and public health audiences. As Grepin notes in her review, though, trying to speak to two audiences that do not often intersect with each other brings its own difficulties with it.

Grepin raises questions about my discussion of disease surveillance systems, saying that my argument goes against best practices in public health. I understand the point she makes about the vitality of preparation and prevention. Disease surveillance systems are designed to highlight the new and novel, and that makes absolute sense for a whole host of reasons. My intention was not necessarily to argue against that strategy. Rather, I wanted to tie it in with larger questions raised by the surveillance requirements within the 2005 revised version of the International Health Regulations, often abbreviated as IHR (2005) (World Health Organization, 2008). IHR (2005) jettisoned the old reporting requirements and their focus on specifically enumerated diseases, instead embracing an all-risks approach that required states be vigilant for any public health emergency of international concern. This new approach requires states to establish and maintain a fairly robust disease surveillance system, which should benefit all of us. The objections raised are not on public health grounds, but rather on political and economic grounds. IHR (2005) came with no funding to support the more extensive surveillance requirements within the treaty. In a number of countries, this has led to debates over how the government should allocate its limited public health budget. Policymakers have asked whether establishing a...
surveillance system is the most effective use of their limited resources or are responsive to the needs of the people. Again, this is not so much a public health debate as it is a debate at the intersection of public health and politics.

The role of non-state actors remains relatively under-explored within the global health politics literature, despite their growing importance. Is PepsiCo’s involvement in groups like the Global Health Council a sign of its recognition of corporate social responsibility, or is it an attempt to deflect attention from its own culpability for growing rates of obesity and diabetes (Boseley, 2014)? Do programs like Product (RED), in which a portion of the sales from specially branded products go toward the purchase of antiretroviral drugs in Africa, allow consumers to ‘vote with their dollars’, or are they cynical marketing efforts that fail to address the underlying causes of Africa’s HIV/AIDS epidemic (Richey and Ponte, 2011)? It is possible that multinational corporations (MNCs) could contribute positively to global health governance, or is their presence necessarily a distortion of the global health agenda for private gain over public benefit? I have looked at some of these issues in previous research (Youde, 2009b), and I tried to address some of these issues by looking at the role of private philanthropic organizations, but they clearly deserve greater attention. Paxton and Roemer-Mahler, both highlight the need to investigate where MNCs fit within global health governance. Paxton raises a number of ways in which MNCs have taken an active role in global health governance without receiving much attention. Pharmaceutical companies could theoretically be partners for promoting drug access, but Busby notes that they can also distort markets and insist upon intellectual property rights protections that keep people from getting the drugs they need. MNCs could help fill some of the budgetary gaps facing the World Health Organization (WHO), but would they restrict how their contributions could be used? That could distort WHO’s agenda – but it is important to remember that WHO’s agenda is already significantly distorted by the extra-budgetary funds given by wealthy nations for specific purposes. Although I cannot resolve these questions here, the fact that these questions exist shows that they need to figure far more prominently in any future versions of this book.

Roemer-Mahler also raises important questions about the nature of the global health governance system and its focus on developing questions. As she points out, this framing raises questions about aid dependency, issue distortion and ties with other elements of global governance. The relationships with other elements of global governance are important, but I found that I could not do them justice within the scope of this current book. (This is one area where Harman (2011) particularly excels). I would agree with her assessment that my book implicitly accepts equating global health governance with global health governance in developing countries. This is simply a reflection, for better or worse, of how the current mode of global health governance has evolved. The focus on infectious diseases and on (initially) framing global health as a security issue have led to a system where we tend to pay attention to illnesses in developing countries not out of altruistic concerns, but out of fears that they could cross borders and threaten the West. By reflecting this system, my aim was not to signal approval or disapproval, but rather show what currently exists. This same logic extends to the relative lack of attention in the book to non-communicable diseases (NCDs), which Busby highlights. While development assistance for health in 2011 totaled approximately US$31 billion, NCDs received only $377 million – slightly over 1 per cent of the total (Institute for Health Metrics and Evaluation, 2014, p. 10). The international community is starting to pay more attention to NCDs, but the global health governance system is still largely oriented toward infectious diseases, and it is uncertain how much or whether the system will need to evolve to accommodate NCDs.

Busby suggests a deeper engagement with the literatures on cooperation within the international system and why states have delegated much of the work on global health to international organizations (IOs). I am a big fan of the work by both Sandler and Barrett on international health cooperation and cited it quite a bit in one of my earlier books (Youde, 2009a), though I did not really address their research in this book. The broader questions about the conditions under which states turn to IOs and whether IOs actually possess autonomous power of their own could be fruitfully explored and deserve greater attention in a future version of this book, though. He also suggests a more extensive discussion of horizontal and vertical programming. The global health governance system has largely organized around disease-specific vertical programs, but recent calls for a Framework Convention on Global Health (Gostin, 2008) and debates about the post-Millennium Development Goals agenda may suggest the emergence of space for an international discussion of supporting programs that aim to strengthen health systems at large.

There is so much more to global health governance than can ever hope to receive sufficient attention in a single volume, and my book can provide but an introduction to these issues. Fortunately, the fact that so many questions remain and that there are more areas that deserve serious exploration means that the global health governance research agenda will not be exhausted any time soon. I offer my sincere thanks to the four reviewers and will take their suggestions into account for any future editions of the book.
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