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Rachel Kiddell-Monroe

A Non-State Centric Governance Framework for Global Health

ISGlobal Barcelona Institute for Global Health

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Executive Summary

Rachel Kiddell-Monroe

LL.M in Bioethics,
McGill University

Something is wrong with global health. While many agree that the agenda should place a priority on improving health and achieving equity in health for all people worldwide,[1] good intentions have not translated into an improved reality on the ground. Despite the promises, the money, the panoply of actors and the political will of States, countless lives are needlessly lost to tuberculosis, HIV/AIDS, sleeping sickness, diarrhoea, diabetes, to name but a few. Even when key ways to address these issues are proposed, they do not see the light of day. Take the critical proposal for a Medical Research and Development Convention to stimulate the research and development of new treatments for neglected diseases. After 14 years of efforts, it was on the brink of success and ready to be negotiated at the World Health Assembly 2013. Yet, it was delayed yet again by a global health governance process driven by political and economic national agendas rather than the interests of people, equity and social justice. As the WHO Director General Margaret Chan has said, it seems that global health is "caught in a crosscurrent, with a potentially lethal undertow."[2]

Health and equity are compromised both by the power of different players to influence and enforce the governance of global health and by the existing governance mechanisms used to set the health agenda. The existing global governance system has proven unable to respond to global health crises such as the access to health services and medicines. This paper argues that the current system of global health governance is outmoded and inherently unable to provide a comprehensive and coherent approach that guarantees health for all. Addressing this crisis requires new normative and institutional frameworks suited to the global health reality of today's world and that have equity and social justice at their core. A new framework should (a) ensure inclusive participation which reflects meaningful and collaborative involvement by the plurality of global health actors; (b) rebalance the power asymmetries in global health, including challenging the cooptation of the global health agenda by industry; and (c) ensure that global health remains a meaningful and focused approach, which is not diluted by mainstreaming the concept in every area of the development agenda.

The severity and tenacity of global health challenges compels us to think beyond the status quo. This paper attempts to do that by looking at global health governance from the perspective of institutional innovation and political creativity. It explores the idea of a non-State-centric or multicentric global governance framework as a challenge to the current geopolitical power structure, and builds on the practical wisdom drawn from the reality of governance issues encountered through the access to medicines debate. By incorporating the descriptive insights of several scholars on open source anarchy and nodal governance, a multicentric

framework is presented as a fresh and pragmatic approach that provides the space for reality and innovation in global governance to respond to the calls for equitable and just global health outcomes.

The paper is presented in three parts: (1) the reality of global health and the three realities of its governance (2) why the current system of global health governance cannot address those realities effectively and sustainably and (3) how multicentric global governance for health can provide a sustainable and innovative framework for global health.

I Global Health Today

Despite unprecedented political and financial interest in global health, and despite the plethora of actors and disciplines involved, poorer populations continue to suffer and die from treatable and preventable diseases. While we have seen progress in some areas of global health, such as reductions in child mortality rates, two major health crises are facing the world today: the spread of infectious diseases and the rise of non-communicable diseases (NCDs). Despite massive human and financial resources dedicated to stemming the tide of HIV/AIDS, malaria and tuberculosis,[3] these "big three" diseases continue to disproportionately strike people living in low and middle income countries (LMICs) and remain critical and urgent issues in global health.[4] Meanwhile the growing burden of cancer, cardiovascular disease, chronic pulmonary disease, diabetes and mental health problems has been recognized as one of the major challenges for development in the twenty-first century.[5]

Globalisation has transformed the focus of what was formerly known as international health from the provision of aid from rich to poor countries across borders, to a "globalised public health" that has largely removed those state boundaries.[6] Globalisation was expected to create certain benefits like economic development for all countries bringing increased access to better living standards and health for more people and less poverty.[7] However, the reality is that we are witnessing is a terrible paradox of spectacular economic growth and medical advances contrasted with the ever-widening gaps between the health of rich and poor people.[8] While on the one hand there is unprecedented commitment by States to deal with these crises, bad health policies have led to almost half of the world's people living in extreme poverty and deprivation, lacking access to even the most basic health care.[9]

Change the scientific, political, economic, administrative, and legal environment

The globalisation of public health has led to the globalisation of its governance. The global health landscape is no longer limited to States

and IGOs, but also includes hundreds of public and private NGOs and foundations, as well as scores of global health initiatives and celebrities from the world of music and film.[10] In the absence of a world government, global health needs a template of global governance to manage globalisation's impact on the spread of infectious and non-infectious diseases that have gone beyond the control of any one State.[11] This template of global health governance uses "formal and informal institutions, rules, and processes by States, intergovernmental organizations and non-State actors to deal with challenges to health that require cross-border collective action.[12]

Combined with increased funding for global health, this proliferation has spawned a panoply of regimes and initiatives to address global health problems.[13] As part of this revolution in global health governance,[14] access to essential medicines issues have become a lightening rod for exposing the failures of global health governance by revealing that global health has shifted from a largely humanitarian issue to an increasingly political one. Not only is health seen as a domestic and national security issue but it also lies at the intersection of many critical global political issues, including climate change, migration, economics, trade and health, which link economic development and social determinants beyond national borders. This shift has revealed the inadequacies of existing global governance approaches both by highlighting the elevated status of health in global governance schemes and emphasizing the root causes of ill-health and inequitable health outcomes.[15]

While central to any public health and medical system, medicines remain unaffordable for large swathes of the world's population.[16] Guaranteeing access to affordable and appropriate essential medicines became a global concern when the World Trade Organisation (WTO) adopted the Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) in 1994.[17] By adopting TRIPS, WTO members created an inextricable link between trade and health that impacted their ability to provide affordable medicines to their populations. Flexibilities in TRIPS to ensure poorer countries were not disadvantaged by patent terms were rarely used and in 2001, the WTO adopted the Doha Declaration on TRIPS and Public Health to redress the balance and promote "access to medicines for all".[18] However, today one in three people worldwide still lack access to essential medicines and they live largely in LMICs.[19] As the largest family expenditure item after food, the cost of medicines is the key barrier to accessing treatment.[20] While the United Nations has repeatedly urged countries to improve access to affordable essential drugs in LMICs,[21] the situation has scarcely improved.

Despite the obvious inequity and social injustice in the global distribution of medicines, social justice approaches to health often take second place to market logic of competitiveness or strength. This market primacy can even be considered as a market justice approach to health.[22] This describes how high-income states dominating global health are influenced by their domestic and global economic agenda, which includes the impact of health policy on powerful private non-State actors, creating a strong tendency to define health as a consumer good to be allocated primarily by private decisions and markets. To that end, they adopt measures that define health as a commodity.[23] This "market justice" approach to health focuses on the technological aspects of health, revealed through a commitment to biomedical technology, which admits current predominant economic principles and incentives as drivers for policy.[24] Market justice sees market forces as critical to effective and inclusive development and that, in the global health context, biomedical

approaches represent a critical part of that model. This contrasts with social justice approaches to health historically espoused by the World Health Organisation (WHO) and public interest non-State actors like non-governmental organisations (NGOs). In line with social medicine theories key to the creation of the WHO, this vision of health recognizes that social justice and equity should be the key drivers of health policy and action.[25]

The conflicts inherent between the market justice and social justice approaches represent a fundamental challenge the global health governance model.[26] "Grand challenges" to the current governance model have been correctly identified and include a lack of global health leadership by WHO, the inability to harness creativity, energy and resources for global health, the lack of collaboration and coordination between multiple players, the neglect of basic survival needs and health system strengthening, issues around funding and priority setting, and the need for accountability, monitoring and enforcement.[27] However, addressing these challenges effectively to create a coherent and effective framework requires an understanding of the three realities underlying global health governance today.

Reality 1:
A lack of inclusive and meaningful participation by plurality of actors

The political space for global health has been reshaped.[28] Adding actors to the debate has been critical to many of the advances made in global health, a fact particularly evident in the access to medicines debate.[29] Yet, non-State actors are a diverse sector that present challenges in terms of transparency and potential conflicts of interest. Beyond the public interest groups (NGOs and civil society), it encompasses private interests such as corporations, aligning with market justice approaches to health, and foundations. Pharmaceutical companies are seen to have such a major impact on access to medicines issues that the Millennium Development agenda highlights their role in making essential medicines more widely available and affordable for all who need them in LMICs.[30]

The impact of a lack of attention to the divergent and sometimes conflicting goals existing among non-State actors was revealed in the negotiation of the 2011 *United Nations Political Declaration on NCDs*.[31] UN member states re-affirmed their commitment to the existing global health governance model while acknowledging the need for States to collaborate with non-State actors. At the WHO Ministerial Conference in Moscow,[32] a coalition of civil society groups highlighted the lack of references to TRIPS and Doha in the draft Political Declaration on NCDs that would put access to affordable treatment for NCD patients at risk.[33] LMICs subsequently added references to those documents but a small but powerful group of high-income countries, notably the US and EU, wanted to remove the references.[34] Eventually, the references to TRIPS were heavily watered down in the final Political Declaration presented to the UN General Assembly and references to Doha were removed.

The lack of involvement in the negotiation compromised effective participation by civil society. There was no public justification of the decision to exclude Doha, which made it difficult for non-State actors to respond to the concerns of States and relegated non-State actors to reacting on their best estimate of what happened. This lack of articulation allows assumptions about process to take precedence over evidence-based interactions and gives the sense that decisions are taken with little regard for the discussions occurring in the civil society fora. Informal spaces for civil society become politically correct but normatively impotent.

Who participates in which decision ultimately depends on the priorities of States. Given the magnitude of the NCD crisis and politicisation of global health combined with pharmaceutical companies' interest in supplying NCD medicines to poorer countries, it is unlikely that access to medicines and therefore the health of the poor will be the primary concern of States today.

Reality 2:
Exploitation of power asymmetries in global health

The relative power of corporate and civil society actors has been a central dynamic in the access to medicines debate. Pharmaceutical companies have become important drivers of domestic and global economies and many countries rely on them to support their economies. This was evident in the negotiations around TRIPS. It is firmly established that the pharmaceutical industry played an important role in the direction and tenor of the TRIPS negotiations,[35] a role driven by industry's view that pharmaceutical IPR is their "most valuable resource"[36] and that protecting it is key strategy to their economic success. There is compelling evidence of the influence of the pharmaceutical industry in the US trade-based approach to intellectual property policy[37] and the minimum standards under TRIPS are widely recognised as representing important gains for the global pharmaceutical industry.[38]

Beyond the clear asymmetry in the passage and enforcement of TRIPS, evidence of that power asymmetry has become evident during the fourteen-year effort to put in place a Medical Research and Development Convention.[39] Just one example reported is that an expert working group set up by WHO to evaluate the causes of the lack of drug development for people with neglected diseases leaked confidential commission documents to pharmaceutical industry representatives for comments a full month before the final report was made public.[40] As a result the WHA rejected the Commission's report and the process for addressing the critical needs of neglected patients was further postponed.[41] In the NCD process, industry representatives were able to wield influence by participating in and leading panels on policy and planning during "civil society" consultations, even where civil society representatives were not present on the panel.[42]

Reality 3:
Dilution of global health

Meanwhile, these two realities have contributed to a third reality, which is that global health is becoming another "something, nothing word".[43] Global health has a special character and meaning which is at risk of becoming diffuse and uncertain, and therefore of little normative value. Given the impact of non-traditional fields of governance on global health, global health has been "mainstreamed" throughout the governance system. By integrating global health in all areas of governance from economics to education to environment, the global health label opens doors to funding and political traction. As a result, more and more interest groups will seek to include their issue within the definition of global health, which is not so difficult when the definition is boundless.[44] Just as commentators have raised concerns about how the proliferation of new rights has risked devaluing the "currency of human rights",[45] [46]there may be a risk that the uncontrolled expansion of the global health umbrella devalues the currency of global health.

Lying at the intersection of trade and health, the risks of dilution become evident in the access to medicines and innovation debate. Discussions

in the NCD process showed examples of market agendas being put up against social justice goals when the WHO solicits the engagement of pharmaceutical companies and other industries in developing policies and plans around how to address NCDs. In this way, trade and market driven objectives become entrenched in the development of health policies and dilute the stated goals of securing equity to ensure good health outcomes. Instead of promoting the social justice goals of the Doha Declaration, which protect access to medicines for all, the trade agendas of rich nations appear to dominate negotiation processes once more, so that social justice protections were removed from the final text. While promoting global health is the ostensible goal of the NCD Political Declaration, the meaning of global health is no longer limited to the health of people but extends to the development of economic agendas.

II Can the current system address the reality of Global Health?

Many agree that the global health agenda should place a priority on improving health and achieving equity in health for all people worldwide,[47] yet good intentions have not translated into reality on the ground. There are two broad visions of how to address the current deficiencies in the global health governance system: one recognises the primacy of the State and proposes adjustments to address weaknesses, while the other recognises the need to move to a non-State centric system, arguing that the latter is already in progress and showing promise.

The majority of global health scholars and practitioners recognise the continuing primacy and ultimate responsibility of States in national and global health governance.[48] The global governance model is based on the classic 1648 Westphalian model installing nation States as the primary actors in international relations.[49] This understanding has led to membership of multilateral health organizations, such as WHO, being open only to States.[50] States have also made it clear that they support a State-led approach in any template for global governance and suggest that the international community must recommit to a multilateral system so that all States "rich and poor, engage with an equitable voice."[51]

Proponents of working within the state-centric governance model claim the traditional structure can be adjusted to incorporate the new actors as well as the challenges they bring.[52] Evidence shows that powerful States continue to influence the global health agendas according to their domestic policy goals, as witnessed in the most recent twist in the Medical Research and Development Convention story where the US unilaterally put the convention back on course after years of trying to derail it.[53]

When viewed from a perspective of power struggles, an approach aiming to "renovate" existing structures in the same model appears pragmatic

since promoting global health through various global governance processes is politically sensitive. It touches on questions of state sovereignty and involves the distribution of economic and political resources as well as a "candid assessment of power structures".[54] States would stonewall any moves that challenge their sovereignty, and resist creating any harmonising structure, preferring to limit restrictions on their activities so they can act as they wish rather than seek collective action.[55]

Yet, the apparent pragmatism and realism of adapting the status quo displaces attention from the real issue. A review of the justifications for keeping the status quo and adapting it to meet today's challenges revolves around the needs of the seventeenth century structure rather than the needs of people that structure is supposed to serve. In other words, in deciding how to address the failures of the global health governance system, there appears to be a choice between a pragmatism that suits the interests of States or a pragmatism that suits the interests of people.

A second vision of addressing global health failures takes a fundamentally different perspective to look for solutions. Rather than viewing global health governance from the perspective of existing power structures, it looks at global governance from the perspective of the actual innovative interactions, initiatives and events which are shaping new dynamics between the plurality of actors, including States, existing in global health today. There are important descriptions of the existing reality in global health, which provide a springboard to develop a new pragmatic approach to global governance.[56] These descriptions see the new reality testing the seventeenth century governance approach to its limits[57] and that there is a shift underway to a context where both State and non-State actors shape responses to international health threats and opportunities.[58] By developing and deciding global health policy together, both State and non-State actors are already responding to a new approach to global health governance reflecting the revolution led by globalisation.

There some tangible and relatively successful practical examples of an ongoing move to a more non-State centric approach to addressing global health issues. One example is UNITAID, the International Drug Purchasing Facility that uses an innovative financing mechanism through a tax on airline tickets to raise new funds for global health targeting three diseases: HIV/AIDS, tuberculosis (TB), and malaria. UNITAID has adopted a 12-member Executive Board governance structure that, with its series of advisory and supporting bodies, aims to ensure a broader representation of non-State actors in its decision-making processes. The Executive Board is made up of eight country representatives, two civil society representatives (NGOs and people living HIV/AIDS, TB or malaria), one representative from a major global health foundation, and one non-voting representative from the World Health Organization.[59] A Consultative Forum provides further support to the Executive Board by serving as a platform for debate, advocacy, fundraising and inclusion of partners.[60] The Executive Board as a whole is also supported by a Proposal Review Committee made up of around 20 independent and impartial scientific, public health, market impact and economics experts, and makes decisions on funding objectives, budget allocation, and action plans.

This structure is innovative in global health governance in that it explicitly seeks out the expertise and experience of civil society by makes formal space on the decision-making bodies for their inclusive participation. Furthermore, those civil society representatives themselves are accountable to a broader range of civil society representatives who ensure

that their delegation represents the real voice of civil society. The two civil society members are supported by a broad Civil Society Advisory Group made up of 22 northern and southern NGOs and community groups specialising in access to medicines issues. This group informs the work of the civil society delegations and contributes to policy formulation. A Communities Support Team ensures that one of the civil society delegation is linked directly to the needs of the people in the communities so creating a feedback accountability directly between the communities and the highest decision making body, which is an example of how the voice of patients can directly reach the highest decision making body.

Along with other mixed governmental and civil society governance structures, such as the Drugs for Neglected Diseases initiative (DNDi),[61] the Medicines Patent Pool[62] and the Global Fund[63], UNITAID is an example of an innovative new approach to global health. It address long standing and fundamental global health problems related in particular to participation and power asymmetries by making use of a mixed government and non-state actor governance model to adapt and react to the reality of global health governance in the twenty-first century. These initiatives all show that global health institutions, if they so choose, can find ways to meet the needs of patients and "shed themselves of the characteristics of state-centricity".[64]

III A multicentric vision for governing global health

Building on a ground up and reality based perspective, the wisdom and insights of history and the reality of global health governance drawn from the access to medicines movement, this paper makes the case for a non-State centric or multicentric system of global governance for health. By embracing the need to challenge the outmoded State centric system and incorporating the descriptive insights of several scholars on open source anarchy and nodal governance,[65] it is presented as a fresh and pragmatic framework that provides the space for the reality and innovation of global health governance in the twenty-first century to respond to the call for equity and justice in global health.

There are three key features of a multicentric vision. Firstly, rather than using "global health governance" language, it adopts the term "global governance for health"[66] to understand and incorporate the vastly changed global health landscape with its multiple sources of governance. As opposed to global health governance, global governance for health reaches beyond traditional approaches and analyses the inter-relations between health and other governance sectors to see how their policies and actions affect global health objectives.[67] This is a critical part of the recognition of the new global landscape brought by globalisation with

its new and evolving interdependence between States and non-State actors, where new actors bring new resources as well as their own agendas to the discussion and where health is a cross cutting issue sensitive to a wide range of activities beyond traditional health-related interventions.

Secondly, the multicentric model moves away from a State-centric structure towards a State and non-State actor system. Rather than aiming to create global health architecture, a multicentric approach is a dynamic responsive approach that uses the power of global and local interconnection and networks to achieve health.[68] Trying to capture global health through a single governance structure does not appreciate the fundamental change that health and governance for health is undergoing.[69] With people's global health needs front and centre, the multicentric model seeks flexibility to innovate and reinforce optimal ways to address those needs. It recognises that addressing those needs requires more than mere tinkering around the edges of the structure of the current global health governance model, but rather a fundamental rethink of the traditional governance system.

There are two interrelated descriptions of practice in global health governance today. Rather than attempting to constrain the freedom of action enjoyed by State and non-State actors, "open source anarchy" recognises that in fact open participation of the type being witnessed today can provide key adapted insights into the search for appropriate governance.[70] An anti-architectural approach to global governance embraces unstructured pluralism as providing the innovation and pathways needed to develop a workable system of global governance for health. Examples from the access to medicines campaign show that when innovation and new ideas are encouraged to meet, interact and develop from different spheres, they can give rise the development of normative approaches such as the Medical R&D convention through the elaboration of policy reasons that drive States, intergovernmental organisations, and non-State actors to protect and promote health in world politics.[71]

Yet, there is an understandable concern about the apparent shift to unstructured plurality suggested by the open source anarchy. Nodal governance theory describes a more structured way of understanding unstructured plurality. It has its roots in the elaboration of the contemporary network theory that explains how a variety of actors operating within social systems "interact along networks to govern the systems they inhabit."[72] Whereas open source anarchy embraces the confusion of initiatives and actors like so many pieces thrown in the air to see which ones stick, by understanding governance as nodal we can start to perceive and understand a pattern of social phenomena underlying the creation of policy.[73] Nodal theory is a descriptive model and is not automatically a democratic or an equitable system of governance.[74]

A multicentric model goes further and uses the nodal description as a way to manage the open source un-structure and suggests a normative way to make those inter-nodal relationships network for justice and equity. In this way it acts as a bridge between the perspective of a highly centralised and hierarchical State-centric system and the descriptions of unstructured plurality and anarchy.

Multicentric governance and the three realities

Adopting a multicentric approach can provide a framework in which the three realities of global health governance today can be addressed.

Firstly, it is able to address the central importance of inclusive and meaningful participation by recognising the plurality of roles, responsibilities and interests of the multiple and distinct actors. The chaos in global health is indisputable. There is widespread competition among actors and priorities, a lack of structure and the roles of the different actors are not delineated.[75] Global health has become an intricate and complex web of formal and informal relationships attempting to exert their influence through the State-led global governance apparatus, where bilateral and multilateral relationships pull and push towards negotiated agreements. Using the NCD process as an example, we can see that recognising States, national governments, public and private interest groups as multiple and distinct actors with clearly defined roles would have potentially allowed the NCD process to overcome some of the criticisms about participation. A clear understanding of the distinct role of the various sectors of non-State actors may have enabled the policy discussion space to be framed so as to openly incorporate the plurality of actors and to recognise their equal but distinct authority in the process.

A clear framework of the authority and roles of the different actors could have helped to overcome conflicts of interest and provided a transparent framework for addressing the distinct roles.[76] The NGO consultations and informal civil society forum on NCDs made no attempt to distinguish between the different non-State actors. Indeed, *any* organisation or group that was not a State, that had a demonstrable interest in NCDs and that had applied in time to take part in the NCD process could attend the two "NGO" forums. The result was that the highly resourced pharmaceutical and food companies as well as industry-sponsored patient organisations were indistinct from the classic humanitarian and civil society society groups. A multicentric approach would ensure that each type of non-State actor would be distinguished, would take part in the decision-making process according to its authority, its vested interests in the outcomes and its capacity to impact the issues to advance global health norms.

Multicentric participation does not become an issue of limiting or restricting the number of actors participating in the global governance for health model, it rather becomes an issue of making sure that every actor and its constituent parts has a clear understanding of its own authority, role and its co-extensive relationship with other actors. This could free any global governance for health system from having to decide or choose who is a representative or not, and allow actors to self-select based on their understanding of their role in the process and the role of others. Transparency and a clear framework could help secure a balance between the types of interest represented. By ensuring that decisions are articulated at each instance and by each actor, participation can move towards equitable and effective decision making which recognises the plurality of actors and their contributions to addressing the global health crisis.

With co-extensive roles clearly defined, rather than appearing as a concession to voices of non-State actors, the negotiation processes could be structured to incorporate those voices equitably. The NCD fora in New York and Moscow were framed as consultative and informal. These descriptors alone undermined any authority that the different non-State actors may have thought they had: a reasonable assumption given their critical role in global health recognised by the States themselves. Furthermore, since it is not clear what authority or power if any non-State actors have in the global NCD policy process, States and the WHO may be seen to be acting inclusively simply by granting any type of 'consultative' space

for non-State actors, however compromised. A multicentric model would provide a clear role and authority so that participation becomes a right and not a concession.

Secondly, a multicentric approach can address asymmetry and co-optation by economic interests. A market justice driven system of global health requires trade-offs to be made between different actors that are typically driven by trade concerns rather than social justice concerns lying at the heart of public health[77]. A multicentric approach could provide a policy space in which no actor is excluded but where the potential for co-optation is addressed directly by modulating the influence of conflicting interests systematically through definite roles and clear authority. The global health actors make their claims in an open framework where positions would be heard according to the multicentric principles of distinct roles for individual States and for non-State actors dependent on their authority and their vested interests in the issue at hand. For instance, given the interest that pharmaceutical companies have in protecting IPR, they would therefore not be involved in defining global health policy in which their private interests are at stake. They would not become key actors in a debate on protecting intellectual property as they did in the TRIPS negotiation process[78] and they would not be able to prevent an agreement such as Doha because of their corporate interests in protecting IP[79]. In the NCD debate, while public interest groups saw a need to address IPR as an actual or potential barrier to access, private interest actors focused on prevention and denied that IPR was a barrier. A multicentric approach would have distinguished between the roles of the different non-State actors and allowed the conflicting positions to be openly and critically reviewed to allow a transparent understanding the reasons for the decisions taken. The pharmaceutical companies' role could then for instance be expressly limited to discussing technical aspects of pharmaceutical production and supply to inform policy decisions made by individual States and public interest actors working for the interests of commonly agreed global health norms.

The multicentric approach would require a clear articulation of decisions and positions of all actors and would not have allowed States to exclude Doha from the NCD Political Declaration without articulating their reasons. If States has been forced to explain why Doha had been removed from the Political Declaration, public interest NGOs could have exposed any entrenched interests of the US and EU and allowed them to react either by deciding on a different policy or by using the multicentric framework to challenge the States' decision.

Finally, through providing distinct roles for different actors, a multicentric system could help avoid dilution. For instance, in the NCD process, global health as a normative principle would recognise the relevance of intellectual property to the access to medicines debate. A WHO-type body would be authorised to ensure that non-State actors develop policy focusing on the provision of accessible and affordable NCD medicines for poor patients. While a plan for funding of such a body is beyond the scope of this paper, innovative mechanisms tapping private and public sources to allow an independent and credible institution will be essential. In the NCD process, WHO would be able to counter the dilution of global health principles demonstrated in the overly-skewed prioritisation of prevention over treatment. WHO could come back on the Political Declaration on NCDs and point out that States had failed to protect the global health needs of poor populations already suffering from NCDs and had unduly been influenced by corporate interests in global health outcomes. It would also be able to require States, civil

society and NGOs to develop clear principles to address the treatment of NCDs to prioritise the social justice principles of global health. This would prevent the dilution of global health as experienced in the NCD process to date.

IV Conclusion

The three realities of global health today – the lack of inclusive meaningful participation, the power asymmetry and cooptation by private interests and the risk of dilution – consistently undermine efforts to reform the existing system. Innovative proposals such as the Framework Convention on Global Health, which suggests a normative framework to govern global health for equity and justice risks being stymied by its reliance on the State-centric system. For example, addressing participation by non-State actors in global health lies at the heart of the FCGH. Yet the FCGH limits participation to those authorised by States, sowing doubts about how the FCGH can promote equity and justice in participation.[80] This would then perpetuate the "seemingly intractable" problems of global health governance that include "powerful forces which seek to perpetuate the gains which they enjoy and could obstruct progressive means to reduce health inequalities".[81] It is well-known that the State-centric nature of international law fundamentally challenges global health governance because it is unable to incorporate non-state actors in the legal framework for global health governance.[82] In other words, while promoting the participation of non-State actors in global health governance, the authors of the FCGH recognise that the State-centric system may not in fact be able to incorporate that very participation. As a result it is unclear in practice how proposals relying on the State-centric structure would avoid maintaining a status quo that relegates non-State actors to an informal role.

Trying to re-purpose an outmoded State-centred governance model to fit the new purpose of equitable participatory governance for State and non-State actors seems doomed. By "clinging to the old models, working ever harder to fit the phenomena we observe into the forms of the past",[83] we continue to leave global health issues in the hands of world's richest and most powerful countries and individuals. To continue this way is simply unethical, given the gross inequities in health outcomes it is causing.

Descriptions of the reality of governance from radically new perspectives today open the door to challenging that perpetuation of outmoded but politically expedient structures on a new and rapidly developing pluralistic and interactive context. A multicentric approach to global governance for health can provide a framework for a system which moves from a description of the globalised reality to an adapted normative ap-

proach which bridges philosophical gaps and addresses equity and justice in global health by dealing with the three realities undermining global health governance today. There are some practical individual examples like UNITAID that show how this model is beginning to emerge. However, there needs to be a more systematic approach to incorporate multi-centric principles throughout the system.

It is never easy to challenge the status quo. However, the reality demands that policy makers identify and address the real reasons behind the failure of the architecture to right the global wrongs, preventing people and nations from emerging equitably and sustainably from poverty. It is not enough to simply accept a structure put in place nearly 400 years ago when the world was a completely different place with far fewer recognised states and limited internationalisation.[84] Globalisation has impacted our world in a way not seen since the industrial revolution in Europe and it is time for global governance to reflect that. We need to recognise the shifts in governance already taking place and challenge outmoded structures as the pragmatic option to meet the desperate global health needs worldwide. Moving to a non-State centric system challenges us to embrace a fresh, open perspective and an understanding of a dramatically and rapidly changing world order. If global health needs are to be addressed, we need to start thinking outside the box.

1 Jeffrey P Koplan et al. , "Towards a Common Definition of Global Health" (2009) 373 Lancet at 1393.
2 Margaret Chan, "Steadfast in the midst of perils", online: WHO <http://www.who.int/dg/speeches/2009/steadfast_midst_perils_20090428/en/index.html>.
3 See generally www.UNAIDS.org and www.globalfund.org for detailed information of the HIV/AIDS crisis and the funding and human resources dedicated to addressing the big three diseases.
4 David P. Fidler, "The Globalization of Public Health: Emerging Infectious Diseases and International Relations" (1997) 5:1 Indiana Journal of Global Legal Studies 11.
5 WHO, WHO Discussion Paper for Informal Dialogue with the NGO Sector in the preparation of the UN High Level Meeting of the General Assembly on Noncommunicable Diseases (New York: WHO, 2010).
6 S Benatar & R Upshur, "What is global health?" in S Benatar & G Brock, eds., *Global Health and Global Health Ethics* (UK: Cambridge University Press 2011) at 14.
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