March 2002 witnessed an important event in the history of international health: the Global Fund to Fight Aids, Tuberculosis and Malaria announced its first round of funding (Ramsay 2002). This was the first time that developing countries were able to access a billion-dollar Fund to support their efforts to address three long-standing health issues of utmost seriousness. In face of the threat posed by HIV/AIDS to people everywhere, the world, it seemed, had stopped and taken a breath. It had decided to depart from “business as usual” and to defy the socioeconomic divide between North and South, which commonly determines whether or not a person whose life is threatened by devastating illness will get access to life-saving treatment. The stakes were high, as were the hopes for the new organization.

The Global Fund was conceived of as a new kind of organization, one that will “not belong to one set of countries, or be tied to the United Nations, the World Bank or other institutions,” but would be a “genuinely international entity” and also, at the same time, a “partnership between the public and private sector” (World Health Organization 2002a). Although the rich countries of the world dominate the health policy agenda, along with several other priorities, the Fund promises to allow developing countries to shape the response to some of their most pressing problems, with the support—yet without interference—of richer countries, and through a partnership among governments, the private sector, civil society, patients and their representatives, and the Fund itself.

The creation of the Global Fund illustrates larger trends of globalization at work in the world today. Increasing connectivity in trade, finance, and communications is leading to growing political, economic, and cultural
integration. At the same time, certain problems are increasingly conceived of as “transnational” in the sense that they do not stay confined to the geographical or political spaces of individual nation-states—HIV/AIDS, climate change, and migration are prominent examples. Along with the view that some problems transcend national boundaries has come a perception that existing institutions, which are based on principles of national sovereignty and international cooperation, are inadequately equipped to solve those problems. Alternative models of governance are needed (Reinicke 1997; Nye and Donahue 2000; Brundtland 2002; Martens 2003.). The world is witnessing a gradual shift away from the traditional system of governance, which relied on governments, and intergovernmental organizations alone toward a system in which multiple actors, both state and nonstate, are playing an increasingly active role.

These trends are particularly visible in the health sector. Not only epidemics like HIV/AIDS and SARS (severe acute respiratory syndrome) but also noncommunicable health problems such as tobacco-related illnesses and cardiovascular diseases are increasingly viewed as global problems. Since the mid-1990s, more than a hundred new health organizations have emerged, independent of the multilateral institutions (Cohen 2006). Their missions vary, from the development of vaccines and drugs for diseases affecting developing countries to the provision of health care to patients in the poorest regions of the world (Widdus 2001, 2005). Some of these organizations are foundations, like the mighty Bill and Melinda Gates Foundation, which has billions at its disposal for research and development of new treatments for diseases that disproportionately affect the poor. Others are not-for-profit organizations, such as the Medicines for Malaria Venture or the Global Alliance for TB Drug Development, which strive to bring new malaria and tuberculosis drugs to the market. A majority of these new players, including most prominently the Global Fund to Fight Aids, Tuberculosis and Malaria, conceive of themselves in some way as “global partnerships” between the public and private sectors.

The idea that partnerships represent a superior way of cooperation marks a departure from traditional public health approaches. International health cooperation as first conceived in the mid-nineteenth century was built on the foundations of the Westphalian regime of 1648, which has governed relations among states for three centuries (Fidler 2003). Three principles are central to that regime. First, states are the primary actors in the international domain; second, rules are designed to address the interaction among states (such as rules of diplomacy, war, and trade); third, these rules should not interfere in the internal workings of states, that is, in the ways that national governments govern their territories and populations (Fidler 2003). International