Global Governance and Health

Abstract: This chapter discusses the relationship, in an age of globalisation, between global health governance and the governance of individual health issues such as HIV/AIDS, pandemic influenza, tobacco control and access to medicines. It does this within the context of changes to global governance more generally. It proposes a new way of envisaging this relationship, which captures the evolving political dynamics. In particular the chapter identifies a narrative of transformative change in global health governance based on three elements: the globalisation of health; the emergence of competing visions of global health governance; and the changing institutional landscape.

Introduction

In early 2007, Indonesia’s Minister of Health, Siti Fadilah Supari, announced her country’s decision to stop sharing its samples of the H5N1 influenza (‘bird flu’) virus with the World Health Organization (WHO). What appeared at first sight to be a fairly innocuous, technical decision, sparked a major diplomatic crisis. Since 1952, the WHO has been identifying circulating strains of the influenza virus to allow the development of vaccines and warn of novel strains with the potential to become pandemic. Central to this is the manner in which samples of the influenza virus are shared on a systematic and regular basis, from 135 recognised National Influenza Centres located in 105 areas, to one of six regionally distributed WHO Collaborating Centres. Here they are analysed to determine which strains are in active circulation and whether a new strain may be emerging (WHO, no date). Virus sharing was therefore widely accepted as a global public good, where mutual interests had produced global norms and institutions to mitigate the potential human and economic costs of influenza.

In this context, the Indonesian decision not only appeared to undermine an example of an effective global regime, but also came at a time when fears of a highly pathogenic influenza pandemic were high, and Indonesia was among the countries seen as a highly likely source of such an outbreak. The general reaction, especially from the United States, was extremely hostile, portraying Indonesia’s actions as reckless and threatening to global health security. Siti Supari, however, argued that virus samples were being passed on, without Indonesia’s knowledge or permission, to private pharmaceutical companies to develop highly lucrative vaccines. Moreover, despite widespread recognition that Indonesia could potentially be the front line of an influenza pandemic, and therefore in greatest need of vaccine supplies, the price set by pharmaceutical companies lay beyond the means of most Indonesians. Further, patent protections had been taken out by companies on the avian influenza virus itself, and Material Transfer Agreements concluded between WHO and pharmaceutical companies, without the consent of those countries providing virus samples. Supari claimed that this practice was ‘obviously unfair and opaque’ (Supari, 2007). Indonesian fears appeared vindicated in 2009–10 when, during the ‘swine flu’ (H1N1) pandemic, high-income countries received privileged access to the relevant vaccine, regardless of who was most at risk from the virus or which governments had provided