THE SHIFT FROM INTERNATIONAL TO GLOBAL HEALTH POLICY: ACTORS, FRAMEWORKS, AND CHALLENGES

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ABSTRACT

During the last two decades, particularly with the acceleration of globalization, there has been a proliferation of new actors in the field of global health. This resulted in a shift from international health governance (IHG) model, which recognizes nation state as the core actor, to global health governance (GHG) model, which incorporates civil society organizations and businesses. This article will explore this shift from IHG to GHG from multiple angles. It will first shed light on the historical origins of this phenomenon and then analyze the role of each actor that constitute these models. This will be followed by an assessment of the tension between vertical and horizontal approaches to global health policy. The article will finally underline the main challenges that are ahead of global health governance. These challenges are neglected tropical diseases (NTD), social determinants of health (SDH), public private partnerships (PPP), and intellectual property rights (IPR).

Keywords: Global Health, Public Health, Policy, Globalization, World Health Organization.

ULUSLARARASI SAĞLIK POLİTİKASINDAN KÜRESEL SAĞLIK POLİTİKASINA GEÇİŞ: AKTÖRLER, ÇERÇEVELER VE ZORLUKLAR

ÖZ

Son yirmi yıldır, özellikle küreselleşmenin hız kazanması ile birlikte, küresel sağlık alanındaki aktörlerin sayısı da çoğalmıştır. Böylece ulus devlet odaklı işleyen uluslararası sağlık yönetiminin (IHG) yerini, sivil toplum örgütlerini ve şirketleri bünyesine katmayı başaran küresel sağlık yönetimi (GHG) almıştır. Bu çalışma IHG modelinden GHG modeline yapılan bu geçişi farklı yönleriyle ele alacaktır. İlk olarak bu değişimin tarihsel arka planına ışık tutacak, sonra da bu iki modeli oluşturan aktörlerin rollerini inceleyecektir. Buna bağlı olarak küresel sağlık politikalarda dikey ve yatay modeller arasındaki gerilimi irdeleyecektir. Çalışma son olarak sağlık yönetiminin karşı karşıya olduğu zorlukların altını çizecektir. Bu zorluklar ihmal edilen tropikal hastalıklar (NTD), sağlığın sosyal belirleyicileri (SDH), kamu-özel ortaklıkları (PPP) ve fikri mülkiyet haklarıdır (IPR).

Anahtar Kelimeler: Küresel Sağlık, Kamu Sağlığı, Politika, Küreselleşme, Dünya Sağlık Örgütü.

Citation: GÜÇLER, A. (2022). "The Shift from International to Global Health Policy: Actors, Frameworks, and Challenges", İMGELEM, 6 (10): 277-294.
Atıf: GÜÇLER, A. (2022). "Uluslararası Sağlık Politikasından Küresel Sağlık Politikasına Geçiş: Aktörler, Çerçeveler ve Zorluklar", İMGELEM, 6 (10): 277-294.
Başvuru / Received: 15 Eylül 2021 / 15 September 2021
Kabul / Accepted: 19 Mayıs 2022 / 19 May 2022
Derleme Makale / Review Article.

INTRODUCTION

Until early 1990s, global health policy was dominated by nation states and intergovernmental organizations (IGOs) where national health ministries were responsible for delivering these services to their citizens. The World Health Organization (WHO), on the other

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hand, played the leadership role of coordinating the allocation of the funds and services at the global level (Ruger 2014). In this specific governance model, there was not much space for non-state actors such as civil society organizations or businesses. Since the late 1980s, however, this trend has changed as these non-state actors gained more prominence in global health. This is called the shift from *international* health governance (IHG) to *global* health governance (GHG) (Kickbusch 2000). This article will explore this shift from IHG to GHG from multiple angles. It will first shed light on the historical origins of this phenomenon and then analyse the specific role of each actor that constitute these models. This will be followed by an assessment of the tension between vertical and horizontal approaches to global health policy. The article will finally underline the main challenges that are ahead of global health governance, which are neglected tropical diseases (NTD), social determinants of health (SDH), public private partnerships (PPP), and intellectual property rights (IPR).

Historical Background

Until the advent of the 19th century, there was almost no cooperation among nation states when it comes to fighting against cross-border diseases (Howard-Jones, 1950). The first practice of international health diplomacy coincides with the mid-19th century when two big cholera pandemics took place in Europe and major cities in Europe like London, Paris and St. Petersburg between 1821 and 1851 (Castellani and Chalmers 1919). The pandemic had blocked the main trade routes and when the merchants were quarantined, this proved to be highly costly for the European powers (McKee, Garner and Stott 2001). Since national policies proved to be inadequate to govern this international crisis on their own, the European powers decided to arrange *ad hoc* meetings to understand each other's needs. This culminated in the first International Sanitary Conference in Paris in 1851, which was followed by others. These international conferences provided a common platform for the European states to discuss and find solutions for the infectious diseases (Aginam 2005). However, these efforts did not yield any overarching principles and permanent international institutions. Without an established secretariat or permanent membership, health was merely seen as an instrument to further trade relations among European powers.

The Paris 1903 Sanitary Conference broke this pattern by creating a standing committee for these meetings (Fidler 2001). This committee allowed the representatives to meet at regular intervals with a permanent membership structure. Such institutionalization was particularly

important to put pressure on the non-signatory states. It also allowed a more efficient exchange of medical information and expertise, which saved health from being overshadowed by trade negotiations. In the aftermath of the 1903 Conference, the delegates from twenty governments from all around the world, which included Brazil, Egypt and the US, offered the creation of an International Office of Public Health. In 1902, the Pan American Sanitary Bureau was created, which was the first international health agency. This was followed by the Office International d'Hygiène Publique (OIHP) in 1907 (Weindling 1995). These organizations harbingered the promise of a growing and regularized international health bureaucracy.

When the WWII came to an end, the San Francisco Conference established the United Nations. In June of 1946, the International Health Conference was organized in New York to erect a permanent international health organization. The conference was composed of 51 members and 13 non-members. In a short period, the conference produced the Constitution of the World Health Organization, which came into force in 1948. This was a historic moment for the evolution of health diplomacy as it unified health diplomacy under a single organization with an expansive mandate. Towards the end of 1980s, the WHO lost its prominence in global health as it was replaced by other organizations. This transition will be discussed in further detail soon (Brown, et. al. 2006). However, for the time being it suffices to say that there were two core reasons for such a shift to happen. First, the intergovernmental organizations such as the WHO proved to be highly inefficient in fighting against specific diseases such as the HIV/AIDS, malaria and tuberculosis. Civil society organizations filled this void with their flexible governance structure and their proximity to the local communities. Second, the end of the Cold War sealed the dominance of neoliberal ideology, which justified a strong involvement by the business sector in public health governance (Lee 1997).

Actors in International and Global Health Governance

While it is true that non-state actors have increased their influence in the new millennium, this should not be interpreted as the receding power of nation states in global health policy. On the contrary, most of health spending still comes from national resources (Held, et. al. 2019). This was best demonstrated by the large sums of money that was allocated to health in fighting against the COVID-19 pandemic. One important reason why states are still the key actor in global health

governance has to do with their longevity (Marten, et. al. 2018). Private sector can gather large funding, but the sustainability of such funding can rarely match state resources. The other reason is states are, at least ideally, accountable structures. Especially in democratic regimes, state officials are elected individuals, which endows them with a legitimacy that non-state cannot have. Also, states are a lot more flexible than assumed as they are able to adapt to new environments (Kickbusch 2000). It would, therefore, be wrong to assume that states are obsolete entities that will lose their place in global health policy with the advent of non-state actors.

The WHO is the main intergovernmental organization that represents states at the international level (Chishom 1950). The broad mandate of this organization, which is "the attainment by all peoples of the highest possible level of health," has been criticized for being too idealistic to achieve realistic outcomes (WHO 1948). However, it should be noted that such broadness has been a key asset for the organization to become flexible enough to adapt to different circumstances. From 1950s to the end of 1960s, for instance, the WHO had to operate in a Cold War environment where international cooperation was impossible to accomplish (Sayward 2006). The organization accordingly adapted to this political environment by narrowing its mandate and targeting specific diseases such as smallpox instead of trying to enact systemic change. In 1970s, the number of members in the WHO increased substantially, most notably through the inclusion of the newly independent sovereign African nations. Such inclusion had important implications for the World Health Organization since the inclusion of these nations, also known as the Group 77, led to more emphasis on poverty and the social and structural determinants of health. This culminated in the Declaration of Alma Ata of 1977 with a specific focus on primary health care and universal coverage for all (Venediktov 1998). It also paved the way for structural reforms in service delivery, which meant that health services had to be organized around people's needs and expectations (Wisner 1988).

In late 1980s, the WHO had to adapt to a changing environment again by becoming more disease-specific since its comprehensive outlook on health had proved to be too impractical (Julio, et. al. 2014). This period is defined by structural adjustments in national economies and a more liberalized trade. As the donors were mainly informed by the private sector and business models, they did not like comprehensive approaches to global health such as the one pursed by the WHO, which tended to be long term whereas the donors did not see quick results. As the WHO tried to

adapt to this new environment, it faced new competition from non-state actors and ultimately lost its authoritative position in global health.

Global Health Governance and the Non-State Actors

The inclusion of non-state actors (i.e. businesses and civil society actors) altered the very fabric of health governance. Unlike nation states and intergovernmental organizations, non-state actors are not made up of elected officials. Also, they do not necessarily have public interest as their priority. For instance, businesses are private actors who are mainly accountable to their shareholders' demand for profit-maximization. This is not to say that businesses cannot be socially or publicly responsible. But social or public responsibility is not their reason d'état (Smith and Lee, 2018). This is the reason why their increased involvement in global health in the last three decades has been quite controversial. Having said that, it would be wrong to talk about businesses in a monolithic fashion since their engagement in global health vary. Pharmaceutical companies have a direct involvement in the health sector as they research, manufacture, and distribute medicine. Private hospitals engage in health not at the level of production, but as a service business. Other private entities such as Amazon are not directly linked to health, but they contribute to health programs to demonstrate their social responsibility and to retain good public relations (Rochford, Tenetti and Moodie 2019).

The inclusion of the business sector in global health governance generated the concept of public-private partnerships (PPPs), which are defined as "voluntary and collaborative relationships between various parties, both public and non-public, in which all participants agree to work together to achieve a common purpose or undertake a specific task" (UN 2018). This trend towards public-private partnerships was made possible by the ideological shift towards neoliberalism around the world and the decreasing trust towards bureaucratic organizations such as the UN. The PPPs perform a wide gamut of functions in global health such as the product research and development (e.g. AIDS Vaccine Initiative), the provision of educational materials for local communities (e.g. the Health Communication Partnership) and management of issues pertaining to health workers (e.g. the Global Health Workforce Alliance) (Balcius 2011). There are, however, growing criticisms towards PPPs. For instance, they are criticized for only caring for health issues with high profit margins, which diverts the attention away from those diseases that cause the

greatest burden to health. The other critique towards these partnerships pertains to sustainability since they do not have guaranteed funding. There is also the issue of transparency/accountability since the representatives from the business sector are not elected officials and their primary motive is to make profit. This creates a democratic deficit in global health governance and perpetuates public mistrust towards these partnerships (Leigland 2018).

The fourth and final category of actors that will be highlighted here is civil society organizations (CSOs). Like businesses, CSOs are also non-state actors, but unlike businesses, they are non-profit. Organizationally speaking, CSOs hold the unique capacity of being flexible entities, which stands in contrast to state bureaucracy. They also have more immediate contact to local communities, which allows them to give more voice to the people and provide education to local populations (Doyle and Patel 2008). Besides their presence on the ground, CSOs have also proven themselves to be an indispensable part of global health diplomacy through their activism. For example, they played an essential role in the WTO Doha Rounds to make drugs more accessible. They were also active participants in the Framework Convention on Tobacco Control (FCTC) to regulate tobacco production and consumption. But the CSOs are also not immune to criticism. Since the funding sources are scarce for these organizations, they are constantly in competition with other CSOs, which creates unnecessary conflict among them and tarnishes the existence of a collaborative environment. Additionally, CSOs can receive large sums of money from states and for-profit institution, which can compromise their autonomy. Their accountability is also under scrutiny since they are not elected by the very communities that they serve (Lee 2010).

Global Health Governance Organizations

Global health governance organizations are hybrid organizations that are composed of a rich variety of actors such as charities, private donors, community organizers, civil society organizations and field workers. This is what makes global health governance a truly inclusive phenomenon, which differentiates is from the international health governance model. There are two organizations that come to mind here. The first one is the Global Alliance for Vaccines and Immunisation (GAVI Alliance), which was founded in 2000 as a response to inefficiencies of the Expanded Programmes for Immunization, which was run collaboratively by the WHO and UNICEF. The Board of the GAVI Alliance is very inclusive with twelve rotating members in total. The members include governments from developing and develop countries, a health institute that

is valued for its expertise, the vaccine industry from one of developed and developing countries, NGOs and a research institute. The Board also has four renewable members, which are the Bill and Melinda Gates Foundation, World Bank, UNICEF and the WHO (Tchiombiano 2019). While the board still has many state representatives, the organization also gives experts, businesses and civil society representatives the right to vote.

The other defining feature of the global health governance organizations is their narrow scope since they focus on only one or two specific diseases. This is different from an organization like the WHO, which has a very broad mandate. The GAVI Alliance's policies are focused on vaccination. However, they cover this specific area from multiple angles such as producing and monitoring rules for distributing vaccines, overseeing the utilization of the pledged funds and implementing the immunization programs. The GAVI Alliance was preceded by global immunization programs that were run by the UN Specialized Agencies. But with the emergence of the GAVI Alliance, these organizations have been marginalized over time as they lacked the capacity to raise large amounts of funding and allocating such funding in an efficient fashion (Birn and Lexchin 2011). It did not take long for the GAVI Alliance to become the main global actor on immunization and relegate IGOs such as UNICEF and the WHO to the status of supplementary partners.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is another organization that aligns with this new organizational paradigm (Patel, et. al. 2015). GFATM is a public-private partnership with a composite board that includes private foundations such as Melinda and Bill Gates Foundation, various representatives from business sectors and people from the affected communities. Towards the end of the 1980s, intergovernmental organizations such as WHO were having difficulties in dealing with the emergence of different global health matters such as AIDS (Buse and Walt 2002). It was in recognition of this problem that organizations such as UNAIDS was established in 1994 and replaced the WHO Global Programme on AIDS (Levi, et. al. 2016). However, similar issues of inefficiency and shortage of funding ensued with the UNAIDS, which led to the establishment of the Global Fund in 2002. The Global Fund quickly surpassed its predecessors and established itself as the leader in this field (Sands 2019).

One of the most cherished aspect of the global health governance organizations is their close collaboration with the business sector. Businesses have the unique advantage of providing direct funding and offering lower the prices in product and services. However, the actual impact of these pricing benefits remains contested. For instance, several pharmaceutical companies have signed pricing agreements with the GHGOs, but these efforts do not always generate price stability (Hardon & Blume 2005). The GHGOs are also criticized for remaining restricted in their contribution to global health not to upset their shareholders. When it comes to lifting the patents on medicines that are deemed as essential for health, the private companies remain hesitant since this would hurt their profit margins. They are also criticized for playing with public perception since their public image do not match what they actually allocate for global health. The Product Red Campaign, for example, partnered with companies like Nike, Starbucks and Apple to raise more awareness about HIV/AIDS in Africa and secure funding to eliminate this disease. It consistently made the news since it features popular figures such as Bono. Yet this initiative raised less than 1% of what the Global Fund has allocated to fighting the disease even though it enjoyed wide publicity (Spethmann 2007; Worth 2006).

Horizontal and Vertical Approaches in Global Health

The emergence of GHGOs resurfaced the tension between disease-specific (or vertical) and comprehensive (or horizontal) approaches in health policy (King 2002; Msuya 2005). As mentioned earlier, in 1970s the WHO had committed itself to building comprehensive systems with a strong stress on primary care. Towards the end of the 1980s, it became apparent that this horizontal outlook was too idealistic to yield tangible outcomes at the global level, which is why it had to revert to the vertical model. Horizontal and vertical models have their own distinct advantages and disadvantages (Mills 2005). Organizationally speaking, the horizontal model arranges health services under a single administrative body and budget. In terms of financing, horizontal programs are publicly funded. Due to its systemic outlook on health, the horizontal model also has a long-term horizon with a desire to create permanent healthcare institutions deeply embedded in the community that they serve for (Mills 1983). Its public character allows poor populations to have access to health. Its access to funding also generates sustainability and stability in health governance (Magnussen et al. 2004).

Despite its positive attributes, this model also has its shortcomings. Most importantly, horizontal programs require well-established infrastructures and a fully-functioning health system whereas in most low-income developing countries health systems tend to be weak with limited resources. This makes the horizontal model a very challenging task to accomplish (Dudley & Garner 2011). For that reason, donors approach horizontal programs with hesitancy and prefer vertical programs since the latter can yield tangible, short-term outcomes. This explains the recent trend from horizontal to vertical programs since the latter is easier to manage and can bypass governmental bureaucracy and corruption (Travis 2004). Particularly in the case of low-income countries, an exclusive focus on comprehensive health systems can yield highly inefficient outcomes (Ooms et al. 2008). This is not to say that the GHGOs overrule the horizontal public options. They rather try to form hybrid systems where domestic programs are supplemented by short-term, predictable, and disease-specific programs.

On the other hand, the vertical model targets specific diseases instead of trying to manage health at the systemic level. Organizationally speaking, vertical policy interventions tend to have their own separate administrative bodies and budgets (Till, Dutta & McKimm 2016). They also generate their own staff who direct, supervise, and execute these highly specialized services. Vertical programs have globally proven to be quite effective in eradicating diseases such as smallpox and achieving substantial reduction in deaths from diseases that can be prevented with vaccines (Cairncross 1997). Particularly in the case of low-income countries, vertical policies have been effective in fighting against those diseases that have not been properly addressed by the horizontal programs. Vertical programs align with the Millennium Development Goals (MDGs). Out of the eight core specific goals of the MDGs, one of them is the goal of combating HIV/AIDS, malaria and other diseases (Hoen 2011).

Vertical programs follow a managerial model of efficiency with a strong emphasis on specialization and focused interventions. This is what gives them the capacity to generate high impact interventions, achieve effective timing in their responses to health crises and evade the burden of establishing an entire health system to launch its programs (Caines 2004). These attributes allow the vertical programs to avoid the risk of delaying services and transferring funding to inefficient channels. Another key advantage that is associated with a vertical approach is its

capacity to raise awareness about underserved communities and underfunded diseases. Since vertical programs provide highly targeted services, it also becomes much easier to track the actors who are responsible for delivering and funding these services. Unlike the complexity and inefficiency of comprehensive health care systems, they are transparent and accountable entities. Finally, vertical programs can be imagined as transitional entities for healthcare systems since low-income nations cannot generate the kind of horizontal structure that they aspire for without well-functioning vertical programs in the first place.

A common criticism that is voiced against vertical programs pertains to the duplication of services. Since vertical programs are detached from healthcare systems, they can offer services that are already present in the system (Ann 2009). Such duplication not only burdens the system, but also generates wage discrepancies and unnecessary conflict among the existing healthcare staff. Vertical programs also fall short of addressing larger questions such as social inequity and the social determinants of health. They also tend to focus on certain specific diseases and neglect others. For instance, they fall short of addressing cases with multiple causes such as cardiovascular diseases, cancer, and disability (Magnussen et al. 2004). Another prominent critique that has been voiced against the vertical model is related to the fact that vertical programs can be quite detached from the local population as they are organized and executed by professionals who are mostly foreign to the communities that they serve. The top-down nature of these programs can end up undermining local initiatives and ownership in planning and implementing health policies.

As can be seen, horizontal and vertical programs have their unique strengths and weaknesses (Ooms et al. 2008). Vertical programs have the advantage of focusing on a specific disease and population, utilizing staff members who are highly specialized in the field, mobilizing resources that are specifically geared towards that purpose, and setting up specific timelines to achieve those purposes. In a nutshell, these programs are efficient and result-oriented. The horizontal programs have the advantage of focusing on each individual and their comprehensive needs, which is particularly important when someone suffers from multiple conditions. They are also better at achieving health equity since they are funded by public resources. Even though these two options have their differences, they can also be complementary. It would, therefore, be a mistake to treat them as mutually exclusive options. Vertical and horizontal models can be mobilized in a coordinated fashion as long as the short-term and long-term objectives of each

program are defined clearly. That is why it makes more sense to think of their relationship in terms of a continuous relationship rather than a disjunction (Heeringa 2020; Oliviera-Cruz 2003).

Key Challenges Ahead of Global Health Governance

Global health governance today faces many challenges (McKee 2001; Owain 2011). Out of the many challenges, neglected tropical diseases, social determinants of health, public-private partnerships, and intellectual property rights regime are the most pressing ones (Frenk 2013). Neglected tropical diseases (NTDs) refer to a group of seventeen diseases that are conventionally in low priority in service and research. These diseases are particularly widespread in sub-Saharan Africa, Latin America, and some parts of Asia. They are classified as endemic in around one hundred fifty countries and are estimated to affect around one point four billion people around the world (Engels & Zhou 2020). However, unlike HIV/AIDS, tuberculosis, and malaria, they are severely underfunded. Only five percent of the global funding for health is allocated to fighting these neglected diseases even though they have a very big negative impact on global health (Kilama 2009). In January of 2012, many pharmaceutical companies collectively signed the London Declaration to fight against the NTDs. However, the momentum on this front has been very slow, which is why it remains a core challenge.

Social determinants of health refer to those social factors that produce a negative impact on health such as income inequality, social exclusion, education level, racial or ethnic differences, social norms, and cultural biases. A country with high unemployment numbers, for example, tends to have heightened levels of physical illnesses, domestic violence, and addiction problems (Donkin 2017). A health policy that takes social determinants seriously focuses on the social causes of health problems instead of dwelling only on symptoms. Having a good conceptualization of the social determinants of health also enables policy-makers to have a long-term approach to global health. Unfortunately, social determinants of health remain low in the list of priorities in global health since policy-makers are interested in seeing quick and tangible outcomes to satisfy their funders (Lee 2008). They, therefore, push for vertical programs and sideline the foundational social questions such as education and working conditions. This was only exaberrated by rapid privatization (Gopinathan 2019).

Another key challenge in global health today is the public-private partnerships. Even though these partnerships are formally much more inclusive than intergovernmental organizations, PPPs pose substantive barriers in membership and representation (Balcius 2011). For example, only a few such partnerships incorporate low-income countries in their bodies. This contrasts with an organization such as the WHO, which has an open-door policy towards all the recognized nations in the world. Also, membership structure in these partnerships are not rule-based and can yield arbitrary criteria (Whyte 2005). Similar difficulties reside in how public-private partnerships designate their experts. The United Nations specialized agencies such as WHO tend to have an organized set of technical experts who are at their disposal. They also have established ways of selecting and mobilizing these experts. In the case of public-private partnerships, private sector can exert its power on expert selection, which can jeopardize the scientific autonomy of these partnerships. Despite these issues, however, it should be noted that the PPPs have made significant contribution to global health governance, which became particularly manifest in the joint efforts to govern the COVID-19 pandemic (Baxter & Casady 2020).

The final, and the most important, challenge ahead of global health policy is the intellectual property rights regime and its impact on health inequity. Until the mid-1970s, political negotiations regarding international trade were mostly reserved to tariff levels. Questions pertaining to intellectual property rights were handled mostly through independent, bilateral treaties (Lee, et. al. 2009). The fact that the intellectual property rights were not governed by an overarching organization such as the WTO until that point in time meant that non-signatory states would have the freedom to use their discretionary power in devising the treaties on intellectual property rights and their limits. This system, however, experienced a transformation in 1994 through the Agreement on the Trade-Related Aspects of Intellectual Property Rights (TRIPs), which produced key changes in the governance of intellectual property rights (WTO 2001). Most importantly, TRIPs centralized the governance of Intellectual Property Rights (IPRs) and set up the WTO as the main authority to enforce and monitor the rules and regulations. The most pertinent consequence of this event was its intolerance towards flexible solutions towards the IPRs since it was meant to produce standards that exceed the specificity of each context (Helbe et al. 2018).

What makes TRIPs particularly problematic in global health is the imposition of strict restrictions on generic medicines. A generic medicine is a perfect replica of a branded drug since

it has the exact dosage and the same effects on the person who takes this medicine. After the introduction of TRIPs, the possibility of producing generic drugs shrunk drastically due to the imposition of strict patent rights. This consequently made the patented drugs less affordable and accessible particularly for the low-income countries. Also, in earlier IPRs treaties, the time limit on patents used to be much shorter and the patents rights were granted with more discretion. Under the TRIPs, the person or the company that holds the patent has a right to it for twenty years, which means that during that time frame, only the patent-holding entity can grant the right to produce the drug and license it to other companies. Licensing, however, does not solve the problems of accessibility and affordability because the patent-holding company still has the freedom to set the price in a unilateral fashion. Adding a historical dimension to the discussion could be helpful here for comparative purposes. Until the TRIPS kicked in 1990s, the enforcement of patents on low-income countries was not the common practice. In the 1883 Paris Convention on the Protection of Industrial Property, which was the main treaty on international patent until the advent of TRIPs, around half of the countries who were a party to this treaty overruled pharmaceutical patent rights altogether. Other countries imposed restrictions on these rights such as decreasing the time length of the patents and allowing the production generic drugs. These restrictions created significant room for flexibility and negotiation, which was overruled with the TRIPs.

Unfortunately, the TRIPs has significantly hindered the option of producing generic drugs. This can be best illustrated by the history of antiretroviral therapies (ARTs). In 1980s, the ARTs were introduced to the market and their initial prices sometimes reached up to $13,000/year ('t Hoen, et. al. 2018). This meant that someone from a developing country would not have access to these drugs due to high price mark ups. But this was before the introduction of the TRIPS, the non-patent holding companies could enter the market and create competition to produce a generic version of these drugs. This would consequently lower the prices for these drugs and render them more accessible. Particularly with the production capacities of Indian companies, these drugs could be purchased around 1/10 of what they costed before. It is unfortunately not possible to say the same thing for the second and third lines of antiretroviral therapies since these technologies were issued after the TRIPs. This curbed the competition among generic companies. The price for these two generations of ARTs remain very high, which created significant barriers of entry for the populations suffering from AIDS in the low-income nations. Recently, there has been some efforts

to create a patent pool to decrease the prices of licensing fees (Burrone 2019). However, the true impact of this initiative is still to be seen.

Concluding Remarks

This article wanted to provide a broad survey of the paradigmatic shift from international health governance to global health governance. To accomplish this task, it first traced the historical origins of this shift. It further reflected on this shift by providing an in-depth analysis of the actors that are involved at both levels of governance. The article particularly focused on the historical evolution of the WHO over the course of decades as this intergovernmental organization shifted from a comprehensive to a disease-specific institution. This article also shed light on the non-state actors and reflected on their advantages and disadvantages in comparison to states and intergovernmental organizations. This led the inquiry to the conflict between the horizontal and vertical approaches to global health. The conclusion of this analysis was that both approaches have their own unique qualities and their relationship should be seen more as a complementary one. The article finally reflected on some of the key challenges that are ahead of global health governance, which include the neglected tropical diseases, social determinants of health, public private partnerships, and intellectual property rights.

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