Gridlock and Beyond in Global Health

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It is commonplace to argue that the cooperative properties of global governance have not kept pace with the growth and associated challenges of globalization. Many scholars and policymakers often claim that the current multilateral order is 'unfit for purpose' (Goldin, 2013), and that cooperation has failed to offer reliable crisis management (Broome et. al., 2015; Gill, 2015; Held & Roger, 2013). Even Xi Jinping has recently stated that multilateralism is 'increasingly unable to deliver long-term solutions for sustainable coexistence' (2016). The predominant view of global governance is that global cooperation is in a 'permanent deficit' (Lamy, 2014), that this condition represents a 'governance dilemma' (Keohane, 2002), and that effective governance has become increasingly 'gridlocked' (Hale, et al., 2013).

In relation to global health governance, assigning such a negative prognoses is not straightforward. This is because global health governance has in many ways witnessed something of a governance boom over the last sixteen years with many positive effects (Youde, 2014). Global health has had an explosion of new international health actors, development assistance for health (DAH), multisectoral bodies, private foundations, private-public partnerships, bilateral initiatives, multilateral initiatives and new policy directives channeled through traditional United Nations mechanisms. Since the year 2000, global health governance has seen the establishment of key global health institutions and governance mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the GAVI Alliance, the Vaccine Alliance, and the 2005 International Health Regulations (IHR), as well as the addition of a number of major private organizations such as the Bill and Melinda Gates Foundation. With this increased interest in health came new promises for aid delivery and global health 'partnerships', which were articulated through the health policy components of the Millennium Development Goals (MDGs), the Paris Declaration on Aid Effectiveness, its reiterations in Accra and Busan, and now within the Sustainable Development Goals (SDGs). In terms of funding, between 2000 and 2013 annual DAH tripled from US10.8 billion to US31.3 billion, signifying an annualized growth rate of over 11% (IHME, 2015).

Nevertheless, despite the growth in DAH and increased calls within the MDGs and SDGs for a coordinated global cooperation in health, it would still be overly enthusiastic to claim that the overall condition of global health cooperation has improved to the point where global health governance is substantially 'fit for purpose', or that global health outcomes adequately reflect the growth of global health actors, DAH and the health risks associated with globalization. Accordingly, although global health governance is unlike some other policy sectors - in that it has witnessed substantially increased activity - it still suffers from its own unique symptoms of gridlock. For example, although there have been some successes in meeting MDGs 4 and 5 (to reduce child mortality and improve maternal health), the consensus is that the goals went largely unmet (UNICFF, 2013). In addition, as in the case of Ebola and the rise of extensively

drug-resistant tuberculosis (XDR-TB), the increased number of institutions and funding streams do not translate into a sufficiently quick response, enhanced coordinated governance, or decisive global health leadership. Furthermore, despite increased DAH, it is still the case that most DAH funding is allocated to select diseases, mainly AIDS, tuberculosis and malaria, which often results in underfunding for what are known as the 'neglected diseases'. Moreover, although there have been excellent efforts to form partnerships within such frameworks as the GAVI Alliance, the Vaccine Alliance and the GFATM, the verdict on the long-term success of these pockets of targeted cooperation remains contested, since there is evidence to question whether these initiatives have translated into long-term health system strengthening or sustainable health delivery mechanisms (Coyne and Williams, 2014; Swanson et al, 2015). When considered at the macro-level, there clearly remains a significant gap between overall increases in institutional growth and DAH and the implementation of policy that delivers effective healthcare, a point that has led some to argue that current practice fails to improve global health outcomes overall (Coyne and Williams, 2014; Swanson et al, 2015). What this suggests is that despite all the growth in health expenditure and attention, global health cooperation remains significantly underperforming.

Against this background, it is possible to locate key indicators symptomatic of global health gridlock as well as a number of recent pathways that suggest there are avenues through it. The gridlock heuristic highlights how the meteoric growth of global health governance since the year 2000 created a condition in which effective global policy-making is increasingly compromised due to rising transaction costs and policy coordination problems, exacerbated by an increased number of health actors that must operate within a narrow policy bandwidth. Viewing current global health governance through the lens of gridlock sheds light on the fact that global health cooperation today is underperforming not simply because it is very difficult to solve many global health problems, but because previous phases of global health mobilization have been incredibly successful in creating a large number of global health actors and programs, which, in turn, have produced unintended consequences that now complicate the coordination and problem-solving capacities of the health regime complex as a whole. Yet, as we explore later in the chapter, there are also a number of potential avenues to increase cooperation and move through gridlock, despite the fact that global health governance, as a whole, continues to remain far from being 'fit for purpose'.

The aim of this chapter is to better understand the role of gridlock within global health as well as to locate potential mechanisms through and beyond it. Accordingly, the chapter first provides a mapping of global health gridlock. Second, the chapter will explore three pathways 'through' gridlock. Although there are potentially many avenues *through* and even *beyond* global health gridlock, this chapter will specifically focus on three key pathways that offer the most promising avenues in current global health governance: 1) A realignment of major power interests around global infectious disease control; 2) Plurality around common International Health Regulations and SDG principles, and; 3) A

reinvigorated trend of innovative leadership by G7 countries and their institutional partners.

1. Pathways to Gridlock in the Global Health Regime

In an effort to understand global health gridlock and potential avenues through it, it is useful to identify four pathways to gridlock in global health governance: rising multipolarity, institutional inertia, harder problems, and institutional fragmentation (Hale et al, 2013). Each pathway can be thought of as a growing trend that embodies a specific mix of causal mechanisms related to global health governance. These pathways, when examined as a whole, often interrelate and conjoin to limit cooperative and effective problem solving and thus represent key barriers for the construction of more effective global health policies.

1.1 Global Health Gridlock and Growing Multipolarity

The total number of states has increased substantially over the last 70 years. More importantly, the number of states that must politically engage on a given issue—that is, the states without whose cooperation a global problem cannot be adequately addressed—has expanded by similar proportions. When the WHO was founded in 1948, it had 61 members. Today, it has over 190 who have to come together to agree on policy initiatives and implementation. Integrating the views of actors at different stages of development, with distinct but varying alignments, not to mention shifting interests, is extremely challenging and often difficult to achieve. The WHO has to achieve consensus between its 193 countries if policy is to be agreed and, accordingly, the weaving of coherent policy outcomes is often impossible (Kichbuch, 2015).

During the Cold War competing interests were largely articulated through the struggle between the US and the Soviet Union. Today alignments are much more complicated as many of the developing countries have grown significantly in recent years and have become major investors and shareholders in the global health industry. As a result, power differentials are more diffused and donor/recipient relations no longer simply map on to the West/South divide. For example, new emerging powers such as Brazil, Russia, India, China and South Africa (BRICS) are having greater influence on global health policy (Harmer, 2014). In addition, the BRICS are able increasingly to exert influence on WHO decision-making (Gautier et al, 2014), to provide access to medicines outside of traditional markets (Yu, 2008), to offer alternative sources of DAH (Chan, 2011; Cabral 2014), and to represent increasingly an alternative to Western 'business as usual' in global health (The Guardian, 2014; Bond and Garcia, 2015).

This increased multipolarity has in many ways helped to undermine WHO authority, since many influential states place more stringent conditions on the WHO and/or seek alternative policy mechanisms outside the UN system. For example, the WHO used to receive three-quarters of its financing from assessed contributions levied on members. However, a change to a zero real growth policy for its regular budget in the 1980s has meant it now only receives one-quarter of its budget from member contributions and is dependent on extra-budgetary

ring-fenced 'pet project' funding from donors to fill an increasingly shrinking budget (Sridhar and Gostin, 2011). As the money flows to bilateral or other multilateral initiatives, WHO authority dissipates, with numerous organizations like the Institute for Health Metrics and Evaluations (IHME), the Bill and Melinda Gates Foundation and Medecins Sans Frontieres (MSF) able to command greater epistemic authority (Shiffman, 2014), financial influence (Frenk and Moon, 2013) and response effectiveness (The Guardian, 2015). Although these new institutions might represent one possible pathway 'through' gridlock, a real consequence of this development is also that many more countries and their organizational favorites (which represent a diverse range of interests) must agree in order for long-term and more effective global cooperation to occur.

1.2 Institutional Inertia and Global Health Gridlock

The 1945 postwar order succeeded, in part, because it incentivized great power involvement in key institutions. From the World Health Organization, to the United Nations Development Program, to the establishment of UNAIDS, to the programmes of the World Bank - key pillars of the global order explicitly granted special privilege to the countries that were wealthy and powerful at the time of their creation (Barnes and Brown, 2011; Hale et al, 2013). This hierarchy helped to secure the participation of the most important countries in global health governance. Today, the gain from this trade-off has shrunk while the costs have grown. As power shifts from West to East (the rise of China), North to South (the rise of BRICS or the G7 to G20), a broader range of participation and coordination is needed on nearly all global issues if they are to be dealt with effectively.

As suggested above, under increased conditions of multipolarity it is becoming increasingly difficult for the WHO to find the authority and resources required to sustain a clear leadership role in global health. Negotiating its way through a landscape of shifting interests, and in an era where collective global action was frowned upon in the face of market triumphalism, it was difficult for the WHO to manoeuver successfully and reshape the organization in such a way that was both responsive and effective. As Kickbuch has observed:

> '…over the last 30 years or so, the WHO member states - despite continuous verbal commitment to reform - have weakened their organization through significantly reducing its budget, refusing to change its regional structure and not being able to agree on the key mandate and functions of the organisation. Many of the policy processes enshrined in the constitution - such as the Executive Board and the World Health Assembly (WHA) have become dysfunctional; agendas are overloaded, meaningful debates are not easy and consensus based decisions are ever more difficult to achieve' (Kickbuch, 2015, pp. 839-40).

The WHO has all too often become a victim of its members' interests at just the time when it needed more independent authority to act decisively. What has happened, specifically in the case of global health, is that many countries now pursue their interests elsewhere in a largely under-coordinated manner with

cooperation often being more about aligned interests than finding long-term solutions to global health needs (Barnes and Brown, 2011; Bruen and Brugha, 2014; Brown, 2015; Kickbuch et al, 2013). This has resulted in a series of negative externalities in global health. For example, those with power hold onto asymmetrical influence through mandatory legal mechanisms like TRIPS and TRIPS-Plus (Muzaka, 2011) and/or through more subtle 'soft-power' donor insisted conditionalities associated with performance-based funding (Barnes et al, 2015); or settle on health priorities that can get broad global support in general terms (like the MDGs), but that leave the details of turning normative rhetoric into a decisive political action still wanting (Kickbuch et. al., 2013).

1.3 Harder Problems and Global Health Gridlock

As interdependence deepens, the types and scope of health related problems around which countries must cooperate has evolved. Problems are now both more extensive and intensive, and this increases the challenge of effective infectious disease control. Infectious diseases and threats such as Ebola, H1N1 (swine flu), H7N9 (bird flu) MERS-CoV (novel coronavirus), Zika, Antimicrobial Resistance (AMR), and XDR-TB have grabbed headlines not only because of their potential global threat, but also due to past and existing confusion surrounding how global responses to transborder infectious diseases are organized (CNN, 2015). Globalization also poses challenges for combating non-communicable diseases, such as heart disease, which are on the increase as Western lifestyles are mirrored within developing countries (Micha et al, 2012).

Moreover, the 'social determinants of health' can be negatively impacted by global factors such as financial crises and unequal economic market conditions (Labonte et al, 2009). There are also major issues stemming from the impact of climate change, which has been predicted to lead to an increase in diseases such as malaria, diarrheal diseases, infectious disease such as HIV and AIDS as well as an increase in serious cardio respiratory difficulties (IPCC, 2014). In fact, there is significant evidence that this impact is already being felt, especially in the poorest countries (Hansen, et al, 2013; Chen, 2013). The problem is that in order to meet these challenges, health diplomacy must navigate a host of social, environmental, and cultural subjects, such as intellectual property, health and environmental standards and financial responsibility —about which countries and international organizations often disagree sharply.

1.4 Fragmentation and Global Health Gridlock

The institution-builders of the late 1940s operated in a far less crowed organizational space with only limited institutional path-dependencies like the League of Nations Health Organization, the Office International d'Hygiene Publique and the Pan American Sanitary Bureau to absorb into policy coordination. But efforts to cooperate internationally today occur in a dense institutional ecosystem shaped by large-scale and multivariate path dependency. The exponential rise in both multilateral and transnational organizations has created a more complex multilevel and multi-actor system of global health governance. For example, in 1909 the total number of intergovernmental

organizations in existence was 37. In 2014, the global health sector alone accounts for 3401 registered international institutions, associations and associated organizations (UIA, 2014). What is astounding is that this number does not include all bilateral health programs, such as those offered by USAID or the President's Emergency Plan for AIDS Relief (PEPFAR), and further excludes many specific programs by multilateral international bodies that may have significant baring on health policy, i.e. the World Bank and UNICEF. This condition is further exacerbated and enhanced by the increase in multiploarity outlined above, since fragmented institutions often become avenues for more traditional forms of state brinkmanship and compliance avoidance.

Within this dense web of institutions mandates can conflict, interventions are frequently uncoordinated, and all too typically scarce resources are subject to intense competition. In this context, the proliferation of institutions can lead to dysfunctional fragmentation, reducing the ability of multilateral institutions to provide public goods. When funding and political will are scarce, countries need focal points to guide policy (Keohane and Martin, 1995), which can help define the nature and form of cooperation. Yet, when international regimes overlap, with multiple funding streams, these positive effects can be weakened. Fragmented institutions, in turn, can disaggregate resources and political will, while increasing transaction costs.

This is an acute problem in global health since nearly all initiatives in high burdened countries are funded by multiple sources. These sources have their own monitoring, accounting and evaluation systems that are often not compatible with one another and/or with local systems. With increased health actors comes increased meetings and evaluations, which is widely reported as one of many capacity restraints faced by already weakened health systems (Barnes et al, 2015). The increased number of actors can also lead to an inefficient division of labor, where actors such as the WHO, Global Fund, PEPFAR, UNAIDS, USAID, BRICS, World Bank, Gates, and Clinton Foundation (to name only a few) often produce parallel programs or bric-a-brac vertical health silos that have not generated overall system strengthening in high burdened countries (Swanson et al, 2015; Montagu and Yamey, 2011). Although this is not always the case, and there are success stories (see below), the problem is that there is undoubtedly a marked level of fragmentation within global health policy, which can lead to diffused responsibility, unclear accountability chains and the potential for certain actors to escape or undermine global norm constraints and progress.

2. Through and Beyond Global Health Gridlock

Although different pathways can carry more significance in some health sectors than in others, the rapid growth in global health governance since 2000 has in many ways generated a condition in which effective global policy-making is increasingly slowed or stalled due to heightened transaction costs and policy coordination problems. While current practice overall does not represent a condition of gridlock, in the sense of the full paralysis of policy making, it is still the case that many areas are exhibiting features of gridlock. That is, a series of

second-order cooperation problems arising from previous phases of success in globalization and increases in global health response now complicate effective problem solving as well as long-term reform at the global level.

Nevertheless, some recent positive trends signal pathways *through gridlock* within the global health regime. Three pathways stand out as particularly germane to global health: 1) A realignment of major power interests around global infectious disease control; 2) Plurality around common principles like the IHRs and SDGs, and; 3) Renewed trends of innovative leadership by the G7 and its institutional partners.

2.1 Global Pandemics and Shifts in Major Powers' Core Security Interests

There has been widespread consensus that 'the Ebola epidemic was a wake-up call for all of us'. This statement, jointly made by Angela Merkel, Barack Obama and David Cameron at the 2015 G7 Summit in Germany, reflects growing concern about the ability of countries and global institutions to respond effectively to the next global outbreak (Brown, 2015b). For example, the Ebola epidemic killed over 11,000 people, infecting over 27,000, and there is widespread recognition by the health community that the WHO (and global health governance more broadly) was poorly prepared to fight the outbreak. Particularly, it is widely held that there was a very slow global response to Ebola, that there was ineffective surveillance of the virus despite long-standing knowledge of its potential threat, that the alarm was not raised soon enough, that there was a general lack of health leadership across all sectors, a lack of coordination and emergency funding, and that there is a general lack of treatment and vaccines in relation to most diseases that represent global threats, including but not just Ebola.

As part of this post-Ebola 'call to arms' two new global financing mechanisms were introduced in 2015 to support health emergency responses. These are the WHO's *Contingency Fund for Emergencies* (CFE) and the World Bank's *Pandemic Emergency Facility* (PEF). In essence, the CFE was the bi-product of continued discussions around the International Health Regulations (IHRs) and was adopted at the Sixty-Eighth World Health Assembly. As part of a more coordinated global emergency response strategy, the CFE aims to fill the gap between the first 72 hours of a declared health emergency and the time at which resources from other financing mechanisms begin to flow. The CFE covers all countries regardless of income in order to prevent an infectious disease from escalating into a public health emergency of international concern (PHEIC), as defined in the IHRs, as well as to respond to other Grade 3 events with substantial public health consequences, whether disease related or not. The fund is triggered by national request and the level of funding is decided on a case-by-case basis (from a $100m fund), which can include funding for personnel, information technology and information systems, medical supplies, and field and local government support. Since its creation in 2015, the CFE has disbursed $8.5 million for a range of interventions related to the Zika virus in South America, Yellow Fever in central Africa, and draught related food insecurity in Asia. Undoubtedly the CFE shows signs of promise, yet the program is still in its infancy and its success will

be determined by how well it continues to be funded, and how well it is implemented as a global first response.

The PEF was established after the final 2015 G7 Communiqué in Germany and is currently in its final design phase at the World Bank with an expected launch at the end of 2016. The PEF was proposed by the G7 as an insurance mechanism that seeks to support and follow up measures in emergencies after initial CFE funds have been mobilized. It aims to do this by providing a surge of post-CFE funding for response efforts to prevent infectious disease outbreaks from becoming costly pandemics with a high global death toll. It notes, for example, epidemic risks from new orthomyxoviruses (new influenza pandemic virus A, B and C), coronaviridae (SARS, MERS), filoviridae (Ebola, Marburg) and other zoonotic diseases (Crimean Congo, Rift Valley, Lassa fever).

The total level of funding for the PEF is estimated to be up to $500 million per outbreak. In many ways, this financial mechanism signals a significant response by major powers to the immediate failures associated with Ebola and thus represents a potentially powerful pathway through gridlock in fighting major disease outbreaks. The PEF will be financed through two delivery 'windows' initially underwritten by G7 countries: an insurance mechanism for funds up to $500 million, and an immediate cash injection between $50 and $100 million. In creating an insurance mechanism, the G7 and World Bank have suggested that the PEF will create a new market for pandemic insurance that will bring 'greater discipline and rigor to pandemic preparedness and incentivize better pandemic response planning'. In addition, the World Bank anticipates SDG 3.8 (universal health coverage – see below) enhancement since it is foreseen that the PEF will 'stimulate efforts by countries and development partners to build better core public health capabilities for disease surveillance and health systems strengthening, toward universal health coverage' (World Bank, 2016). Prima facie, this statement does suggest that the PEF should link into more long-term health system and capacity strategies, thus signaling a potentially robust move through multipolarity and fragmented gridlock. Yet, specific targets for measuring these aims for greater discipline and emergency preparedness have not yet been publicized and without clear enumeration it is hard to see exactly how the insurance scheme will promote health system strengthening of the sort that is recommended by both the IHRs and the SDGs.

Although these new financing mechanisms are designed to fill important gaps in overall global emergency preparedness and demonstrate a level of coordinated interest by major powers, they also raise a number of questions regarding how they might provide a more comprehensive pathway through gridlock. First, these initiatives are the products of two very different global health governance processes, with the CFE being a product of the World Health Assembly and the PEF being underwritten by the G7 via the World Bank. Although both initiatives seek to respond to the failures of Ebola and, hence, to a significant consequence of gridlock, there are concerns that they are not sufficiently joined up in terms of how they link to already agreed IHR commitments as well as how they will draw from, and build, SDGs response capacities within regions and countries. Again, it is important to note that only the CFE has a formal relationship with the IHRs

and thus its catalogue of internationally agreed interventions. The CFE was set up within the context of an IHR recommendation, and located within the wider WHO Health Emergencies Programme (WHEP), as confirmed at the World Health Assembly in 2016. Therefore, unlike the PEF, it enjoys a level of global legitimacy, since it is available to all WHO member states, covers the full spectrum of cross border public health risks enumerated in the IHRs, and is managed under funding rules and institutional frameworks of the intergovernmental body.

Second, there are concerns about whether the 'securitization of health' (with particular emphasis on infectious disease control) within the motivational logic of the major powers can sufficiently address the broader health risks associated with globalization. This is because the 'securitizing of health' prioritizes surveillance and containment, which many argue does so at the expense of more long-term and effective strategies that focus on prevention, detection and care via strengthened health systems (Rushton, 2011; Ruston and Youde, 2014). For example, unlike the CFE, which covers Grade 3 emergencies, the PEF does not specifically mention funding for non-infectious disease related health emergencies, such as chemical poisonings or climate disaster. As a result, it remains unclear, as well as unlikely, that these sorts of health related emergencies would be covered under PEF guidelines. The implication is that these initiatives can at the moment be seen to represent only an investment in the securitization of global health by the G7 major powers, with their limited focus on surveillance and containment of infectious diseases, versus representing broader health initiatives required for reaching the SDGs beyond gridlock.

Third, although the PEF initiative will no doubt have an impact on creating more effective health responses, there are concerns about the 'global' reach of the PEF. Unlike the CFE, only countries eligible for financing from the International Development Association (IDA - the World Bank's fund for the poorest countries) can be beneficiaries of the PEF. This then raises a number of questions about coverage in areas where disease risks remain high. As one example, India is no longer eligible for IDA and thus will remain uncovered by PEF under its current design. This is despite the fact that India continues to have a high disease burden rate as well as significant global health security risks evidenced by high cases of XDR-TB and other forms of AMR such as methicillin-resistant *staphylococcus aureus* (MRSA). As mentioned above, the PEF is not included as a significant element within the WHEP, and is mentioned only as a fund that the CFE should be careful not to replicate. This raises concerns since it is the stated aim of WHEP for the WHO to be the sole coordinator for global emergency response and to limit DAH fragmentation. As a result, it is unclear how well the PEF can effectively cover health emergencies in all cases and about where health emergency relief can reliably be acquired in non-IDA cases (such as in India). Although a tightly aligned CFE and PEF could provide an effective avenue beyond gridlock, there is also potential for further fragmentation between the two misaligned initiatives.

Due to current policy ambiguities it is unclear whether both financial mechanisms can be seen as complimentary additions to more long-term global strategies to build preparedness capacities, and strengthen overall global SDGs responses. In addition, it is uncertain whether PEF will garner widespread 'buy-in' and compliance as the G7 mandate moves forward. This is largely due to lingering doubts about PEF's global representativeness, the fact that it is located outside the IHRs, and because of its perceived lack of political legitimacy. Therefore, as it stands, these emergency mechanisms only represent a possible pathway through gridlock. However, if they remain partly disconnected, and add to the fragmentation of efforts, they could also provide ripe conditions for continued gridlock and underperformance in global health.

2.2 Coordinating Plurality around the IHRs and SDGs

As the Introduction to this volume notes, pathways to or through gridlock rarely operate in isolation. The relationship between major power interests, global health security risks, health regulations, health goals and health outcomes are, as illustrated above, often interlinked within global health governance. As part of the health security discourse it is often recognized that many health systems remain too weak to prevent, monitor, track and respond to emerging global threats. It is not surprising, for example, that Ebola was most prevalent in African countries that had weak health systems. Many health experts have long argued the importance of better implementing the IHRs as well as for renewed efforts to strengthen regional and national health capacities around a set of common goals like the SDGs. For many, including major powers in the West, there is now an understanding that long-term health security is dependent on health system strengthening and increased global governance capacities, and that there is currently a deficit in this regard. This concern has been compounded recently by the fact that many diseases continue to be 'neglected' throughout all levels of health governance and, thus, get inadequate attention until it is often too late to avoid large-scale and highly expensive responses. In particular, over the last five years there has been a new policy focus on a diverse set of WHO recognized neglected tropical diseases (NTDs) that thrive mainly among the poorest and in the most unprepared health systems. It is estimated that 17 of the main NTDs affect more than 1.4 billion people and are endemic in 149 countries. In this way, the scope of potential risks is global.

As a policy response, there have been increasing calls by global health actors for more robust health regulations and strategy targets. In line with the framework presented in this volume, it is possible to understand specific efforts within global health policy to coordinate multiple and diverse organizations around a common set of goals and norms. Although there have been a number of promising and successful policy efforts (such as the Framework Convention of Tobacco Control), there has been two particularly promising cooperative efforts around acceptance and implementation of the IHRs as well as a positive norm diffusion associated with the newly adopted Sustainable Development Goal 3.8, which focuses on universal health coverage (UHC).

The IHRs were adopted by member states in the World Health Organization (WHO) on 23rd May, 2005. They require that all countries have the ability to detect, assess, report and respond to potential public health emergencies of international concern at all levels of government, and to report such events rapidly to the WHO to determine whether a coordinated, global response is required. Under the agreement, countries were given until 2016 to prevent the spread of risk by developing core capacities to determine the control measures required, provide logistical detection capability, create investigative mechanisms, boost internal and external communication capabilities, and create robust national response plans (WHO 2005).

The main coordinating feature of the IHRs, and thus the IHRs' main mechanism for steering policies through gridlock, is the requirement that all state parties must have established the minimum public health core capacities by June 2016. From self-assessment reports sent to the WHO in 2015, many countries have made progress since 2012, most notably in surveillance and laboratory capacities, in legislation and in human resources (WHO 2015), including through an Integrated Disease Surveillance Response (WHO Afro 2015). In this way, the IHRs have provided a consistent policy focus to align multisectoral actors and regulate compliance. However, less progress has been reported regarding emergency preparedness, in capacities at points of entry to countries, and in dealing with chemical and food safety risks, suggesting poor preparedness in dealing with a wide range of public health risks (SEATINI and TARSC 2016). What this suggests, in terms of movement beyond gridlock, is that although common norms, regulations and goals have the ability to generate common policy drivers and outcomes, the effectiveness of those outcomes still rely on consistent reinforcement via financial and technical cooperation. Given the fact that the IHRs have only been partly met suggests that, despite widespread normative agreement, a more concerted effort to promote all aspects of IHR compliance is still needed. Without this the IHRs might lead to continued underperformance and gridlock, specifically as PEF and other non-aligned programs scale up.

In order to mitigate gridlock it is necessary to strengthen the implementation of the IHRs so that they can act as the primary framework in the global health security agenda. As part of this the IHRs will require better short, medium and long term strategies and targets that work in a complementary manner, with funding directed to the full set of implementation capacities as well as more emphasis on sustainable funding for longer term health systems strengthening. Adopting this approach could offer new avenues through gridlock long-term, since a strength of the IHRs is that they are not limited to addressing emergencies after they have started, but also to build public health capacities to detect, prevent and control them. As a policy umbrella, other global health security measures could be aligned to the IHRs (see concerns with PEF above), and to measures in countries and regions, to build systems to detect, prevent, manage and respond to public health risks and emergencies. This would not only increase coverage, but also effectiveness.

In terms of providing additional overarching policy uniformity, one of the great innovations of the Sustainable Development Goals is that it situates all global development activities within its 17 development goals and 169 targets. In this way, if taken seriously, the potential for institutional pluralism to act as a mechanism for gridlock could be diminished by the SDGs. This unifying element is enhanced by the recent adoption of SDG 3.8, which enumerates universal health coverage (UHC) as the primary organizational norm. The norm is defined as the objective that 'all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship' (WHO, 2015b)

It is too soon to determine the positive affects of the SDGs on global health policy coordination and its ability to counter gridlock. Nevertheless, there are a number of positive signs suggesting that the SDGs, and in particular UHC, could provide, what Keohane and Martin (1995) have described as, a necessary focal point for more coordinated global cooperation. First, unlike the MDGs, the SDGs have had a long and inclusive deliberative process that included an Open Working Group of 70 countries, a series of UN sponsored "Global Conversations", 11 thematic consultations, 83 national consultations and several door to door surveys so as to capture population preferences. As a result, the SDGs enjoy a sense of perceived legitimacy and self-legislation, which should translate into improved compliance and implementation. Second, there is agreed recognition about the failures of the MDGs and there has been an upsurge in political will not to repeat past mistakes. Third, there is significant evidence suggesting that a majority of countries are already incorporating the SDGs into their national health strategies, which illustrates that the SDGs are already delivering some of their planned coordinative effects. Fourth, although the SDGs are clearly overly ambitious in terms of scope, they do help to sharpen development aims by framing them against 169 measurable targets. As part of this performance based model, it will be easier to track progress, locate policy and resource gaps, and to demand accountability in cases of non-compliance (for both developed and developing countries). Fifth, as will be discussed in the next section, the SDGs - and particularity UHC – has been diffused and adopted by the major powers and key institutions as a master concept and norm. For example, UHC has been explicitly stated as the guiding norm in global health development by key institutions such as the G7, G20, G77, the World Bank, the GFATM, the GAVI Alliance, PETFAR, the New Development Bank, the BRICS, the EU, USAID, AU, ASEAN, all UN agencies, BMGF, and many more. Sixth, the link between the SDGs, UHC and health system strengthening is being driven by key global health leaders as well as by a majority of developing countries (see below). This starts to address a main failure in MDGs thinking, but also sharpens long-term health development aims that seek to end DAH dependency cycles and underperformance. In this respect, there are promising signs that the SDGs will at least enjoy faster and more sustained affect than the MDGs, which could alleviate disjointed multipolarity, underperformance and policy fragmentation.

2.3 New Global Health Leadership by the G7 and Associates

As stated above, pathways through gridlock overlap and there are often multifarious policy interplays between the motivational interests of major powers, the norms and institutions created to secure those interests, and the diffusion of those norms across sectors. Moreover, these governance pathways are often intersected and influenced by specific global health leaders who can produce innovations within existing pathways or construct new pathways to fill existing deficits. These leaders can be motivated by shifts in self-interests in alignment with others or by broader recognition of the need for norm entrepreneurship in the face of collective action problems. In global health it is possible to witness an increased number of new and old actors assuming leadership roles in an effort to navigate through existing health gridlock.

In terms of non-traditional leadership the last ten years have seen the rise of influential global foundations such as the Bill and Melinda Gates Foundation (BMGF) and the Clinton Foundation. Although there are meaningful debates about whether organizations like BMGF have disproportionately positive or negative authority in global health policy, it is impossible to ignore the massive funding provided by these foundations as well as their ability to provide epistemic leadership. In the case of BMGF, its leadership in global health has led to the creation of the IHME, and it has become the largest donor to the GFATM during the financial crisis, and a key broker in a number of key health initiatives centred around evidence based policy making in health.

Although innovations associated with non-traditional leadership sources can be effective, it is still the case that most global health innovations are driven by powerful states and their collective coordinating and financial power. For example, there is a long tradition of G7 leadership giving a vital injection of political and financial support to global health. Perhaps the best illustration of this is from the 2000 Summit in Okinawa, where the then G8 agreed to support the establishment of GFATM. In Japan the G8 stated that diseases like HIV/AIDS, malaria and TB were having large-scale negative affects on global economic growth, development and health security. In order to curb these threats, the G8 facilitated the creation of the Transitional Working Group to design the new institution, while also pledging an initial funding round of 10 billion USD to help launch the institution's funding efforts. This act of leadership has had profound impacts on global responses to infectious disease (although adding to fragmentation). According to the GFATM, the estimated result of this particular leadership injection has been the saving of 17 million lives since its establishment in 2002, with an additional 2 million lives predicted to be saved each year. Moreover, the Fund's efforts within participating countries has equated to a 40% decrease in new HIV/AIDS cases, a 29% reduction in tuberculosis, and a 48% decrease in new Malaria infections since 2002. Although a direct causal pathway between these reductions and the interventions of the GFATM is difficult to determine (due to the fact that national programs also play a huge role), it is clear that the GFATM has made a significant contribution to improving population health.

More recently, as a direct response to the failure to meet MDG goals 4 and 5, the G7 provided the catalyst for the creation of the Global Financial Facility (GFF).

Designed as a financial component to the SDGs, GFF was announced in September 2014 to help close the funding gap for reproductive, maternal, newborn, child, and adolescent health. In order to enhance greater collaboration, the fund is delivered through the World Bank, but in compliance with the UN Secretary General's Every Woman Every Child Global Strategy 2.0. As part of the GFF, a total of 62 high-burden, low and lower-middle income countries are eligible to receive grant resources. As of now, the GFF is phasing in its operations, beginning with an initial set of four "frontrunner" countries—the Democratic Republic of Congo, Ethiopia, Kenya and Tanzania, with Bangladesh, Cameroon, India, Liberia, Mozambique, Nigeria, Senegal and Uganda announced as the second wave of GFF countries to be funded from 2016. Countries are eligible for between US$10 and US$60 million over a three to four year period.

Again in an attempt to move through gridlock and correct past response failures to diseases like SARS and Ebola, the G7 in 2016 reaffirmed the WHO's central role in coordinating rapid and effective responses to public health emergencies as well as restating the G7's commitment to the Global Health Security Agenda (GHSA). As part of the overall health security agenda, the G7 urged the WHO to implement rapidly its emergency reforms, including the full roll-out of its One WHO approach as well as calling on the international community to support the WHO's new CFE, which enables an injection of money and technical expertise within 24 hours of a declared emergency. The G7 has also assigned the creation of PEF to the World Bank, as noted earlier, and invited the international community to further lend their financial and technical support to PEF. In a welcome shift of discourse, the G7 has now also made an explicit request for better alignment of the CFE and PEF initiatives, in order to protect against gridlock by creating a more comprehensive and coordinated global health architecture.

In response to similar concerns raised in the sections above, there are also renewed efforts by the G7 to link explicitly the IHRs to the GHSA as well as to key health related initiatives, such as the Joint External Evaluation (JEE) tool, the Food and Agriculture Organization's (FAO) food nutrition efforts, the new Health Emergency Program, and the World Organization for Animal Health (OIE). In addition, the G7 is backing AMR programs as part of GHSA by promoting and financially stimulating efforts associated with the One Health Approach, and its connection to the IHRs, the 2016 High Level Meetings on AMR at the United Nations, the EU Ministerial One Health Conference, the Tokyo Meeting of Health Ministers on AMR, and the GHSA AMR Action Package. Although it is too soon to determine whether leadership here will help move beyond gridlock by linking various health security streams, these meetings do offer the opportunity for creating more robust and cooperative strategies.

In making a clear link between the IHRs and other health security activities, the G7 has suggested that the IHRs are a key mechanism for better organizing global health governance. This has significant meaning since by promoting the IHRs the G7 has effectively advanced a policy mechanism that has traditionally generated a high level of 'buy-in' from the WHA, the 196 signature countries, as well as a majority of high disease burdened communities. In addition, in the face of widely

recognized disease response failures, the IHRs represent a crucial detection and prevention mechanism that, in principle, strengthens protective measures against pandemic diseases. What this potentially signals, when viewed optimistically, is a move toward a more legitimate alignment of global health policies, in which the internationally agreed IHRs can help steer and legitimate on-going global health policies through gridlock.

Yet, perhaps the most significant leadership move through potential gridlock relates to the G7's recent recognition of the importance of UHC and its necessary connection to health system strengthening. What is most promising in terms of breaking gridlock is the fact that the G7 positioned UHC as the overarching normative framework in global health. This was done by bringing key global health initiatives under the umbrella of UHC as a master concept. For example, the G7 positioned the work of both the WHO and the World Bank as essential representatives of a UHC approach to health. In doing so, the G7 also listed key new initiatives such as the GFF as needing to fit into an overall UHC framework. What is perhaps most promising in terms of global health effectiveness is the fact that the G7 has also linked the GHSA to the health systems strengthening approach, which stresses a long-term global health strategy from the ground up and affirms that security and health systems are co-constituted (Brown and Stoeva, 2014). As the official G7 Leader's Summit Declaration states:

> 'We reiterate our commitment to enhance our support and coordination to strengthen health systems, especially in developing countries, to make them more resilient, inclusive, affordable, sustainable, and equitable. To this end, we emphasize the need for a strengthened international framework to coordinate the efforts and expertise of all relevant stakeholders… we support the establishment of UHC 2030 that seeks to ensure the International Health Partnership principles… and to promote and catalyze [through establishing a UN envoy] efforts toward UHC across different sectors.'

The implications of this leadership position on UHC are potentially dramatic. First, by presenting UHC as a master concept in global health, the G7 has effectively signaled their 'buy-in' to SDG 3, as well as to its most ambitious target for UHC. Second, by doing so, the G7 endorsed the UCH 2030 Alliance, which seeks to create a political and coordinated forum that can deliver on SDG 3.8. By backing this initiative, the G7 solidified the Alliance's role as a key international health partner and further gave the forum the needed authority to help manage the complexities of global gridlock. Third, the emphasis placed on 'country-led HSS' as a means to effectively deliver UHC is also important to note. Although it is too early to tell, G7 commitments could represent the kind of normative shift that many global health experts have been arguing is needed to move beyond gridlock. Finally, it is necessary to underscore the significance of linking HSS to long-term health security, since a failure to do so in the past has often been a source of criticism – where health security favors surveillance and containment rather than HSS, which itself favors long-term preventative strategies aimed to remove future threats through strengthened health systems (Rushton, 2011; Brown and Stovea, 2014). Although it is clear that health security is still the

dominant motivator for the G7, and there are still concerns about the role of PEF within the IHRs and SDGs (see above), it nevertheless could represent a significant first step towards a more sophisticated and comprehensively long-term global health strategy through and beyond gridlock.

However, there remain reasons to be cautious. First, although the G7 supported better coordination through the UHC 2030 Alliance, they have not yet offered financial support. Second, in relation to AMR, the G7 has remained lackluster in promoting cooperative research and development opportunities. One argument for this reluctance relates to traditional issues surrounding intellectual property rights and concerns for the protection of G7 corporate interests. Although this reading might be overly cynical, it remains the case that the G7 has only been vaguely willing 'to consider potential for new incentives to promote R&D', stopping far short of providing any tangible leadership or financial commitment. At present, the exception has been Britain, who pledged over £300 million to finance national and global support for exploring new collaborations and research in AMR.

Having said this, it would, all things being equal, be churlish to overlook the G7's positive leadership role in global health since 2000 as well as their seeming reenergized efforts to better coordinate global policies since 2014. In particular, the G7 shows revitalized interest in embedding the language of UCH into the global health lexicon, thus providing additional opportunities through gridlock via common norms and goals. In this way, renewed leadership in global health by G7 countries offers some needed pathways through gridlock while suggesting that once again, like with the creation of the GFATM in Okinawa in 2000, the G7 can lay the seeds for more fit-for-purpose global health policy. The key, however, is making sure that these new global health initiatives take stock of past fragmentations that resulted from rapid and uncoordinated growth, so that they are joined up and guided by a limited number of rules that promote coordinated follow-through politically and financially.

3. Conclusion

In many ways the three pathways above represent potentially powerful mechanisms through gridlock. Although there is still much more that needs to be done in order to unravel existing gridlock - in particular to limit counterproductive competitiveness in DAH and unclear institutional jurisdictions - there are some promising signs. The key is to recognize that expansive sectorial growth in global health without meaningful coordination can disrupt and undermine the effectiveness of global health policy. As a result, there needs to be recognition of the importance of better partnerships not just more partnerships, since more does not always equal better (Barnes and Brown, 2011). Recognition of gridlock can help us search for a politics beyond gridlock and to strengthen current initiatives that provide realistic pathways through it. In addition, by applying gridlock as a heuristic device we are able to assess critically new efforts to coordinate global health policy (like between INRs, PEF and CFE) as well as highlight potential areas of under-coordination that could exacerbate existing underperformance.

Understanding conditions of gridlock and avenues through it represents a hugely significant and important task. In global health governance this becomes particularly true as we embark on the monumental task of achieving the SDGs, while also facing acute health challenges such as the rise of AMR, the health affects of spreading Western diets, increasing climate related disease, and amplified social determinants of health associated with growing global inequalities. Thus, it is only by recognizing the conditions of gridlock and by creating pathways through them that global health policy will be able to tackle the health related collective action problems that threaten our planet (Bruen and Brugha, 2014; Brown, 2015a; Kickbuch et al, 2013; Ooms, 2014).

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List of Abbreviations

(AMR) Antimicrobial Resistence
(ASEAN) Association of South East Asian Nations
(AU) African Union
(BMGF) Bill and Melinda Gates Foundation
(BRICS) Brazil, Russia, India, China and South Africa
(CFE) Contingency Fund for Emergencies
(DAH)Development Aid for Health
(EU) European Union
(FAO) Food and Agriculture Organization
(G7) Group of Seven
(G20) Group of Twenty
(G77) Group of Seventy Seven
(GFATM) Global Fund to Fight AIDS, Tuberculosis and Malaria
(GFF) Global Financial Facility
(GHSA) Global Health Security Alliance
(H1N1) Swine Flu
(H7N9) Bird Flu
(IDA) International Development Association
(IHME) Institute for Health Metrics and Evaluation
(IHRs) International Health Regulations
(IPCC) International Panel on Climate Change
(JEE) Joint External Evaluation System
(MDGs) Millennium Development Goals
(MERS-CoV) Novel Coronavirus
(MRSA) Methicillin-resistant Staphylococcus Aureus
(MSF) Medecins Sans Frontieres
(NTDs) Neglected Tropical Diseases
(OIE) World Organization for Animal Health
(PEF) Pandemic Emergency Fund
(PEPFAR) President's Emergency Plan for AIDS Relief
(PHEIC) Public health emergency of international concern
(SARS) Severe acute respiratory syndrome
(SDGs) Sustainable Development Goals
(TRIPS) Agreement on Trade Related Aspects of Intellectual Property Rights
(UHC) Universal Health Coverage
(UN) United Nations
(UNICEF) United Nations Children's Fund
(USAID) United States of America International Development Program
(USAIDS) United Nations HIV/AIDS Programme
(WHA) World Health Assembly
(WHEP) WHO Health Emergency Programme
(WHO) World Health Organization
(XDR-TB) Extremely Drug Resistant Tuberculosis