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HISTORICAL DIMENSIONS OF GLOBAL HEALTH GOVERNANCE

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Introduction

This chapter aims to highlight the potential of historical analysis as a means to provide context for the concepts and definitions mobilised in discussions of global health governance (GHG). We argue that many aspects of current debates and activities were inherent in the nineteenth and twentieth centuries and the role of international organisations. The recent discourse of ‘globalisation’ represents changed forces within international health , and as such deserves unpacking as a political construct ,the subject for contemporary history.

History and global governance

The ideas and claims embedded in the concept can be usefully broken down into *globalisation* and *global health governance*. Globalisation is a much debated and contested concept. It has been described as the ‘widening, deepening and speeding up of the world interconnectedness in all aspects of contemporary life’ (Held, McGrew, Goldblatt and Perraton, 1999). Held *et al* (1999) argue that:

...the world is rapidly being moulded into a shared social space by economic and technological forces...[and]... developments in one region of the world can have profound consequences for the life chances of individuals or communities on the other side of the globe. For many globalization is also associated with a sense of political fatalism and chronic insecurity in that the sheer scale of contemporary

social and economic change appears to outstrip the capacity of national governments or citizens to control, contest or resist that change. The limits of national politics, in other words, are forcefully suggested.

The consequences for health of globalisation are the subject of much analysis (e.g. Lee, 2003a; Lee, 2003b; Lee and Collin, 2005; Labonte and Schrecker, 2006). The debates around GHG arise because globalisation is seen to have specific health consequences that cannot be effectively addressed by existing forms of health governance. The emergence or intensification of trans-border health risks such as global climate change or the role of international corporations, appears to challenge existing forms of international governance (IHG) which are defined by national borders. Global issues, it is argued, may be partially or wholly beyond the control of governments (Lee, 2003a). The potential weakness associated with forms of governance anchored around the co-operation of nation states points to the growth in number and influence of non-state actors in the national, international and global arena e.g. civil society groups, non-governmental organisations (NGO), social movements and private companies.

Like globalisation, global health and global health governance are ‘slippery’ concepts which have eluded attempts to define them with any degree of clarity. Health governance refers to, ‘the actions and means adopted by a society to organise itself in the promotion and protection of the health of its population’ (Dogdson, Lee and Drager, 2002). Such organisation can be formal or informal, the mechanisms of governance can be local, regional, national or international, and health governance can be public or private or a combination of the two. This description of health is difficult to operationalise

historically, because of its almost boundless nature. The associated idea of good governance, which emphasises the need for governance mechanisms and organisations that are appropriate, representative, accountable and transparent, is more specific and clearly located in an historical trajectory – the emergence and expansion of concepts of liberal democracy. Historically speaking these concepts are associated with the development of the European nation states, a feature implicit within the above definition of health governance (the way society organises itself to protect its population). And herein lies a key element in the emerging paradigm of GHG, and an important claim concerning the distinction from existing forms of international health governance (IHG).

Ideas of good governance (representative, accountable) fit well with the nation state and the nation state and with forms of IHG that are anchored in the co-operation of states; and therefore still serve discrete constituencies. However, are such concepts applicable to the kind of social and political spaces that now exist between and beyond states? According to the literature on GHG the proliferation of such spaces is a recent phenomenon, both a consequence of and a response to globalisation. The increased number and influence of non-state actors operating in these spaces, individually or in association with a range of other state and non-state actors, is considered a defining feature of the transition from international to global health governance: and one requiring the implementation or adaptation of recognised concepts of good governance. Our following survey however indicates that many of those issues -the mix of public and private in international health; the influence of groups and organisations not formally associated with the state; and the health consequences of globalisation- are not new but recognisable from the past.

The development of International Health Governance

The development of international co-operation in health can be considered over four periods:

- (1) The nineteenth century and the first international sanitary conferences;
- (2) The interwar period, with the establishment of international organisations, such as the League of Nations (LN) and the rise of the American foundations;
- (3) The immediate post-war era, dominated by the history of the World Health Organisation (WHO);
- (4) The more recent period since the 1970s with the proliferation of new players at the international level.

The International Sanitary Conferences, 1851-1903

The beginning of international health co-operation i.e. the co-operation of two or more states, is traditionally located in the series of international sanitary conferences held between 1851 and 1903 (Goodman, 1971; Howard-Jones, 1975). However Harrison has argued more recently that a cut off point came in 1815. Prior to that date, quarantine was used for objectives other than public health, but afterwards the nature of international relations changed (Harrison, 2005). The spread of epidemic diseases, especially cholera and yellow fever was an important motive force. The two cholera pandemics that engulfed Europe between 1830 and 1847 were facilitated by the increased movement of goods and people between East and West, which accompanied developments in international commerce: steamships, rail and later the construction of the Suez Canal. The long established response to epidemic disease

such as the plague was to close ports and impose quarantine, but that proved difficult to sustain in the age of international commerce. Quarantine measures and disruption to shipping served to undermine the maritime economies of nations like Britain and France, whereas the speed of steam ships meant that people and goods would have disembarked before a disease declared itself. The international sanitary conferences emerged as a mechanism for responding to the political and economic threat which a new epidemic disease like cholera posed to the European powers.

Political and commercial issues were the primary concern of the first conference held in Paris in 1851 and attended by diplomatic and medical representatives of twelve governments. Commerce and competition were high on the agenda. The Middle East was not only the area through which epidemics reached Europe, but was also the key arena in which European powers had jostled for position since the 1830s. Economic and imperialist conflicts surfaced at regular intervals throughout the subsequent conferences convened between 1859 and 1903. For example, the 1885 Rome conference was provoked largely by Franco-British tensions in Egypt. Britain occupied Egypt in 1881 and dominated the 'sanitary council' of Alexandria (one of a series of regional councils). Italy and France resented Britain's anti-quarantine stance when cholera broke out in Egypt in 1893. Britain retaliated by threatening to divert shipping away from the French-run Suez Canal because of French claims that cholera was being introduced from British India.

The conventions and regulations that emerged from the majority of these conferences were never successfully ratified by participating governments. But in 1903 a conference held in Paris produced what Goodman describes as the ‘first effective convention’ (Goodman, 1971, p.23). The 1903 convention formed the basics of the regulation governing quarantine on land and sea until World War II. In 1903 representatives of twenty governments including the USA, Egypt, Persia and Brazil, as well as European nations, recommended the establishment of an International Office of Public Health. The Office International d’Hygiène Publique (OIHP) was established in 1907. It was based in Paris but maintained close communication with the regional ‘sanitary councils’ and the health authorities in various countries. The primary function of the OIHP was the collation and dissemination of epidemiological intelligence. Governments were obliged to inform the Office of the steps being taken to implement the sanitary conventions and the Office could suggest modifications. The OIHP’s co-ordination with regional ‘councils’ and its focus on the health authorities of states pre-figures the organisational emphasis of later bodies, such as the WHO.

The establishment of the OIHP marked the transition from the era of international conventions to that of permanent international health organisations, of which the Pan American Sanitary Bureau (PASB) was the first in 1903. The idea of an international commission for the notification and exchange of information on epidemics had first been proposed at a sanitary conference in 1874. The consensus that began to emerge at the close of the century is best understood in relation to a range of forces; the most

immediate of which were the cholera epidemics of 1883 and 1897. However, the development signalled by the emergence of the first international health organisations was part of a broader movement toward international co-operation, which had been growing in range and complexity throughout the nineteenth century. And it is in this broader movement that key aspects of the debate on GHG have some resonance.

The broader international context of international co-operation

The century from the Congress of Vienna (1815) to the outbreak of war in 1914 saw the emergence of wide-ranging international co-operation in many areas: law, economics, labour, religious and intellectual movements, social and welfare organisations, and humanitarian causes. According to Lyons, there were nearly 3000 international gatherings in this period and the creation of more than 450 private or non-governmental international organisations (INGOs) and over 30 governmental ones (Lyons, 1963, p.12). Developments in transport and communication facilitated this level of international activity, and national governments vied for the patronage of international conferences. Many of these gatherings and organisations addressed health issues, broadly defined, and as Figure 1 suggests, non-state actors played an important role in nineteenth century internationalism.

FIGURE 1 ABOUT HERE (see p.38 for figure)

Developments that can be considered as having a health dimension can be broken down into two fields: intellectual co-operation and consensus in science; and social, religious and humanitarian movements.

Disputes concerning the aetiology of diseases such as cholera bedevilled many of the early international sanitary conferences. Scientific developments, such as Snow's work in London and Koch's in Germany, had no impact on the conferences that followed these discoveries (1859 and 1885 respectively). But effective co-operation in areas of science and medicine did make progress through the century (Crawford, 1992). Initially this took the form of international congresses on specific areas, for example, the first statistical congress (1853), the first congress of ophthalmologists (1857), the first congress of chemists (1860). Many of these went on to form international committees and associations. The statistical congress of 1853 initiated the preparation of a nomenclature of the causes of death that would be applicable to all countries. This was adopted and revised at subsequent meetings and taken forward by the International Statistical Institute formed in 1890. International associations that cut across different areas of specialisation also began to emerge, such as the Association of Academics (1900) which brought together leading national scientific associations. Intergovernmental co-operation in areas such as measurement and mapping developed largely from these international initiatives, for example, the International Geodetic Association (1867), and the International Agreement on the Unification of Pharmacopoeial Formulas for Potent Drugs (1906).

At the close of the century the momentum for co-operation between non-state actors, and later between states, focused on the exchange of information, and represented the first moves towards an international vocabulary (standards, classification) in medicine and science. The social, religious and humanitarian movements that emerged in the

nineteenth century were more complex and diverse in their development. Many were characterised by popular and even mass support but there was also the pattern of conferences leading to more permanent committees or organisations. A burgeoning middle class and the spread of evangelical religion supported many of the activities, whereas the shared experience of industrialisation and urbanisation spawned common social problems across a number of states. The first of four International Congresses of Charities, Correction and Philanthropy met in Brussels in 1865. These were followed in 1869 by a new series of international congresses on public and private charity that met at irregular intervals up to 1914. According to Lyons, these meetings were attended by representatives of a wide range of philanthropic organisations and the discussions covered a broad spectrum of issues: food production, alcoholism, prison conditions, medical assistance to the poor, rehabilitation, infant mortality and the protection of women and girls (Lyons, 1963, p.264). In 1900 an international committee was formed and a bureau of information and studies followed in 1907. This 'umbrella' association emphasised the need for information exchange and an increasing number of governments sent representatives to its conferences.

A number of international 'single issue' reform movements also came to the fore, a development seen as early as 1840 with the International Anti-Slavery Conference and later the International Committee of the Red Cross (1864). In the health and welfare field these associations could be popular in orientation or focussed on specialist expertise. Some, such as the congresses on alcohol, and the resultant International Temperance Bureau (1906), mingled both activism and science (Bruun,

Pan and Rexed, 1975), as did the international Central Bureau for the Campaign against Tuberculosis (1902), which emerged from a series of international conferences dating back to the 1860s. The pattern here seems to be one of initial activity by non-state actors in the international arena leading to greater inter-governmental involvement. The relationship between national associations and national governments would need to be explored in greater detail to understand the mechanisms involved. Interestingly, it seems that many of these movements were characterised by a mix of governmental, voluntary and local activity, such as the policing on conventions around the 'white slave trade', which stemmed from the 1899 International Bureau for the Suppression of Traffic in Women and Children (Lyons, 1963, pp.274-285).

A significant development at the close of this period was the establishment of a platform organisation, the Central Office of International Associations in Brussels (1907), an organisation that changed to the Union of International Associations (UIA) at the first World Congress of International Organisations in 1910. This co-ordinating centre for international activity produced a wealth of documentation, including annual indices, which provides the most comprehensive guide to international activity at the turn of the century, although it has yet to receive sustained historical investigation (Seary, 1996).

The interwar period

The interwar period was characterised by two interrelated developments, the rise of a new style of international corporate philanthropy, such as that developed by the Rockefeller Foundation (RF) and the establishment of permanent international organs in particular the League of Nations (LN). The interwar developments have received detailed historical investigation. In discussing the main developments of the interwar period (corporate philanthropy and the LN) the depth and degree of inter-linking between them should be noted, in terms both of financial support and personnel. For example, the League of Nations Health Organisation (LNHO) drew between a third and a half of its budget from the RF (Weindling, 1995, p.137). Indeed, the relationship is described by Dubin as symbiotic and tied to the creation of an elite of biomedical and health specialists at the centre of a worldwide biomedical/public health episteme:

The RF helped Rajchman [the League's medical director] recruit staff; awarded travel grants to individuals visiting Geneva; recommended persons for expert bodies; made its own staff available for special purposes; helped assess requests for technical assistance; provided additional help to governments receiving LN assistance; and funded its own schools, laboratories and institutes of persons engaged in the LNHO (Dubin, 1995, p.72).

This level of involvement by the RF and the creation of an international cadre of public health expertise is subject to on-going historical debate. Historians have discussed how one interprets the role of American foundation involvement in international health during a period of US political isolationism - was it benign philanthropy or American

imperialism by private means? And how does one interpret 'social medicine' - as a movement to place medicine on a socio-economic and humanitarian basis or as the spearhead of professional imperialism? These debates echo concerns raised in the GHG literature, especially in relation to the contemporary role of corporate philanthropy and public/private partnerships.

The role of American Foundations

The years between 1901 and 1913 witnessed the coming into being of a new form of philanthropy, characterised by the RF and other largely American institutions – the Milbank Memorial Fund, Commonwealth Fund, Sage Foundation (Bulmer, 1995). This new form of philanthropy developed a research oriented view of social improvement and introduced a wider, international dimension to research and sponsorship activities, especially in the area of science and medicine. The scale of RF's financial input into the LNHO has already been noted, but the foundation also developed its own initiatives through its International Health Commission (1913) and through support for clinics, training schemes, school of public health and laboratory services through the world (Berliner, 1985; Farley, 1995). Importantly, the RF pursued a much more interventionist and ameliorative programme than the American government was willing to contemplate at the time i.e. the RF backed the LNHO although the US was not a member state. For some historians, however, the RF is seen as a stalking horse for wider American political interests, and as a central agent of biomedical imperialism – exporting a US model of public health across the world (Arnove, 1980; Birn and Solorzano, 1999).

More recently however the complexity of the RF, and its degree of autonomy and awareness that its programmes changed over time have come to the fore. Undoubtedly, US political interests were furthered by RF involvement in the LN and through its programmes for example in the Far East (Manderson, 1995) and in Latin America (Cueto 1995; 1997). According to Gillespie's work on Australia and the Pacific Islands, 'There were no simple imposition of an American model on compliant local populations' but 'a complicated process of bargaining and compromise [that] led to local interests dominating the implementation of the Rockefeller programme' (Gillespie, 1995). Moreover, Weindling emphasises the relative freedom of the American foundations, as they were without public or political constraints and had no need to placate the interests of the medical profession as such (Weindling, 2002) For example, in the aftermath of the First World War RF support helped develop a system of socialised primary health care in Serbia, and contributed to primary health care initiatives in the US and abroad. This relative freedom also enabled the foundations to support 'unpopular' health issues i.e. the RF provided backing for child guidance and mental hygiene, and the Commonwealth Fund targeted mental health during the interwar period (Thomson, 1995).

Through its focus on training and institution building the RF was fundamental in creating an international network of public health experts. Drawing on the universalism of science, the RF emphasised technology transfer and the exchange of trained personnel. During the interwar period instruments developed in America to measure community health performance were transferred to Europe via the RF (Murard, 2005). As Murard notes it was not a simple case of applying the American 'Appraisal form for Community

Health Work' on European nations, but rather involved reframing and transforming the instrument into the LNs' collection of 'Life, Environment and Health Indices', a much broader instrument than its American 'parent'. This approach is seen by some to accompany the scientisation of social policy on the one hand and the primacy of professionalized, increasingly technocratic solutions to public health on the other i.e. the RF's disease eradication campaigns in Latin America became increasingly laboratory based, and Gillespie noted a similar trajectory in Australia and the Pacific Islands (see Farley, 1995 for this transition).

International Health and the League of Nations

The technical agencies of the League of Nations, the Health Organisation and the International Labour Office (ILO) followed a similar pattern to that noted in the RF programmes i.e. a narrowing of focus. Initially the ILO had an expansive vision of its role in health and welfare, legitimised by the Treaty of Versailles which assigned it the role of protecting 'the worker against sickness, disease and injury arising out of his (sic) employment (Weindling, 1995, 139). But the broad vision was restricted early on.

Weindling comments,

... in seeking to justify its reformist demands in the universalist terms of science, it had to devolve initiatives to scientific experts whose empirically based approaches were necessary limited to what could be proven in the laboratory' (Weindling, 1995, p.139).

Consequently, its focus became overly technical, anchored around the production of scientific evidence of the health effects of particular hazards. Moreover, despite its

overall premise that welfare was determined by socio-economic conditions, no attempt was made to correlate economic trends with the mortality and morbidity data present in its labour statistics.

The LNHO, the agency with responsibility for public health and social medicine showed a similar narrowing of focus, signalled by its separation from the Social Section in 1920 (Miller, 1995)¹. The primary concern of the LNHO in the 1920s was the scientific universalism of standard setting, in terms of biological and morbidity/mortality statistics (Sizaret, 1988; Cockburn, 1991, Mazumdar, 2003). Indeed, by 1937 approximately 72 per cent of the world's population was covered by LNHO statistics. This emphasis on international standards did however, provide leverage for broader health debates during the economic depression of the 1930s. The LNHO developed co-operative programmes with the ILO that focused on developing social medicine on economic bases – how diet, housing, economic conditions shaped health were key area of research. Scientific expertise served radical reform in areas like nutrition, as British scientists criticised their government by invoking nutrition standards endorsed by the LNHO/ILO – forcing them to raise the minimum standards used in calculating unemployment and maternity benefits.

The international health section of the LN was like its successor the WHO, was anchored around the health ministries of participating national governments. However, through the 1930s the LNHO sought greater autonomy, aided by RF money. In moving towards independent research initiatives and settling optimum standards it hinted at the kind of autonomy condemned by some contemporaries: the LNHO should not presume to

‘constitute itself as super-health authority which supervises or criticises the public health administrations of the world’ (Sir George Buchanan 1934, quoted by Weindling, 1995, p.143).

‘Unpopular issues’ such as sexually transmitted infections were championed by voluntary initiatives and kept at a distance from arenas dominated by state actors (Weindling, 1993). It has already been noted that the RF did provide support for mental health initiatives, whereas the ILO focused primarily on economically productive sectors of the population (not the elderly, disabled or mentally ill), and the LNHO avoided the politically controversial issue of birth control. In one case, that of illicit drugs, a separate system emphasising control of trade, although in the interests of health, was set up in the interwar period. A series of international conventions following the Geneva Convention (1925) established and extended an import certificate system together with limitation of manufacture (Berridge, 2001).

Historically, a particularly interesting aspect of international health in the early twentieth century is that initially there were voluntaristic models for a world health authority, led by the League of Red Cross Societies (LRCS). In line with the new form of philanthropy epitomised by the RF, the LRCS, an off-shoot of the American Red Cross, sought to move away from sporadic relief towards securing community based welfare (Hutchinson, 1995;1996). In relation to the LN and its technical agencies, the LRCS was involved early on but later this relationship changed to one where the League was less interested in NGO opinion (Seary, 1996, p.23). This distancing process can also be seen in the

reorganisation of the LN's Committee on Social Questions, which became entirely governmental in 1936. The UIA mentioned above, was also sidelined by the development of the LN, which moved the focus of INGOs to Geneva and away from Brussels (the home of the UIA). In 1929 the Federation of International Institutions came into being in Geneva and by 1938 grouped together 42 INGOs, addressing technical matters on the running of INGOs (taxes) and far less ambitious than the UIA.

War, the United Nations and the World Health Organisation

The history of international health in the second half of the twentieth century represents the largest and most organisationally complex era of developments in this field. The key difference in the postwar context is one of scale, mainly the scale of participation i.e. a significant rise in the number of states, the number of intergovernmental organs and specialised agencies and the number of NGOs. This rise in scale and complexity has been intimately related to fundamental shifts in geo-political structures, such as the dismantling of nineteenth century colonial empires and the rise and fall of the Soviet bloc. Other significant developments, more specifically related to health and medicine, have also marked the postwar decades, such as the rise of the pharmaceutical and biotechnology sectors, and new health threats like atmospheric pollution, emerging and re-emerging infectious diseases such as HIV and TB.

The most significant and well documented event in the organisation of postwar international health was the creation of the World Health Organisation (WHO) as a specialised agency of the United Nations (UN) in 1948. The origins and development of

WHO are covered in a series of 'in-house' or 'insider' histories covering the central agency and the regional offices (WHO, 1958; WHO, 1968; Howard-Jones, 1981; Manuila, 1991; WHO, 1998). More critical 'outsider' accounts by Siddiqi (1995), Lee (1997) and Brown, Cueto and Fee (2006) have considered the various roles played by the WHO in the shift from international health to global health. This is now an expanding area of historical interest. (AHA, 2008; Global Health Histories, 2008). A number of interrelated themes emerge for example, regionalisation, the emergence of political blocs, the issues of politicisation and the shifting paradigms of disease eradication, primary health care and health sector reform. The issues raised in the literature tend to focus on the role of international health in development issues. However, it is arguable that international organisations have also been of great policy importance in relation to the policy agendas of developed countries as well. The Global Programme on AIDS, for example, disseminated an international ethos of human rights in both developed and developing countries. Concepts of drug and alcohol addiction and dependence gained authority through their association with WHO expert committees (Berridge, 1996, Room, 1984).

The regional structure of WHO is largely an historical legacy, in that pre-existing regional organisations were absorbed into the new specialised health agency. The six regions (Eastern Mediterranean, Western Pacific, Europe, Americas, Africa, South East Asia) developed from earlier regional structures like the Pan American Sanitary Organisation. Siddiqi (1995) argues that this decentralised structure, which delineated broad areas and assigned countries to particular regions was problematic from the start.

At the foundation of WHO there was no discussion of potential problems, such as the peculiar delineation of compact geographical boundaries, or the possibility that regional organisations would come under the influence of regional blocs. For example, Pakistan chose to be in the Eastern Mediterranean rather than in SE Asia with India and Afghanistan.

Independence movements and the political nature of regional alliances have been fundamental forces operating in the UN system and its agencies since their inception (Amrith, 2006). For example, WHO had 48 full members in 1948 and this had risen to 183 full and two associate members by 1993. Although the action of political blocs was not new (for example, the mass withdrawal of socialist states in 1949-50), the structural and political inability of WHO to absorb the newly emerging post-colonial nations meant that new formations, based on differences in wealth, joined established Cold War distinctions of ideology. In response to what was seen as a disparity between voting strength and financial contribution between rich and poor nations (Talbot, 1994; Siddiqi, 1995) the 1960s and the 1970s saw emergence of blocs, such as the Geneva Group (made up of states that contributed the majority of funds to UN/WHO) and the Group of 77 (an international interest group representing developing countries). North-South (donor/recipient of aid) became a new axis of political and ideological conflict in postwar international health.

The 1970s onwards

This axis structured debates around the ‘politicization’ of WHO in the 1970s and 1980s, such as in the 1985 World Health Assembly (WHA) resolutions on Arab health in the territories occupied by Israel, and the health impacts of economic sanctions on Nicaragua. The alignment of developed – developing countries was clear in the passing of resolutions WHA38.15 and WHA 38.17, as the US, Israel and most western countries voted against (Siddiqi, 1995, p.8-9). It was also reflected in the attack on the marketing policies of transnational corporations when the WHA adopted an International Code for the Marketing of Breast Milk Substitutes. This was the culmination of international protest on the issue, and followed an earlier WHA resolution (1974) and the call for a boycott of Nestlé products by the Infant Formula Action Coalition (INFACT) in 1977. NGO led activism of this kind was a development from nineteenth century single issue concerns. The ability to generate a consumer boycott of a global product range on a health/development issue was new (Walt, 1993).

A broad based philosophy of health, which was more sensitive to local requirements and distinctions, and was anchored around the provision of primary health care gained ground at WHO in the 1970s (Cueto, 2004). The clearest expressions of this development were the Declaration of Alma Ata (1978) which emerged from the International Conference on Primary Health Care, and ‘Health for All by the Year 2000’, a global strategy emphasising social justice, equity and the link between health service provision and a nation’s socio-economic development (Koivulsalo and Ollila, 1997, pp.109-136). Historically, one can see echoes of the LNHO’s work in the 1930s in the development of

the 1970s (Siddiqi, 1995, pp.193-195). In the 1930s and in the 1970s international health organisations began to emphasise primary health care (PHC) and an understanding of the economic underpinnings of health. The terminology of ‘ new public health’ and ‘ health promotion’ also began to spread in developed countries through international initiatives such as the Ottawa Charter (1986) (Kickbusch, 2003; Berridge, Christie and Tansey, 2006). Economic crisis formed the backdrop to developments in both decades, although the new postwar axis of North-South and the greater representation of poor nations in the machinery of international government led developing countries to demand a New International Economic Order (supported by the Alma Ata Declaration).

PHC also followed on from critiques of the vertical (disease specific) programmes developed by WHO in the 1950s and 1960s, such as the Malaria Eradication Programme (Siddiqi, 1995; Lee, 1998) and the Smallpox Eradication Programme in India (Bhattacharya, 2004; 2006). Greenough (1978) argues that the use of coercion and intimidation in the final stages (1973-75) of the Smallpox Eradication programme in SE Asia, led to local resistance amongst both health professionals and public to later vaccination campaigns. One of the engines behind PHC was the evidence of successful, low technology community health care provided by China’s ‘barefoot doctors’; China gained membership of WHO in 1973. According to Lee (1997), the examples of China and Cuba, which were successfully mobilised by the Soviet Union, challenged the prevailing ideology of the WHO rooted in biomedicine. This challenge also encouraged a renewed interest in traditional medical practices and personnel and during the WHA’s of 1974 and 1974 delegates from a range of developing countries began speaking of their

traditional medicine as a positive affirmation of their native cultures (Lee, 1997, p.38). Moreover, the renewed interest in horizontal programmes (health concerns as a whole, rather disease specific) and the emphasis on appropriateness and community involvement pointed to a more inclusive disciplinary mix in international health. As a former WHO official noted in 1975, in reference to the Malaria Eradication Programme , ‘money, time and effort has been unstintingly spent in the belief, seemingly, that the basic laws of ecology and social anthropology would be lifted to allow a magical disappearance of the disease’ (quoted in Lee, 1997, p.29). However, despite Lee’s somewhat romantic account of WHO’s reorientation it should be noted that while the organisations regular budget was frozen in the early 1980s, the majority of extrabudgetary funds were still directed to disease or technology specific programmes (Koivusalo and Ollila, 1997, p.115-119). Selective primary care, supported by UNICEF, Rockefeller and heavily influenced by the US, began to replace the more inclusive version (Brown *et al*, 2006).

Although ‘Health for All’ may have provided a new ideological touchstone for international health, Alma Ata was still based largely on the assumption that states would play the major role in health provision and health development; Alma Ata did not highlight NGOs and non state organisations more generally. The primacy now accorded to NGOs developed in the 1980s and during a period when major donor countries pursued anti-statist policies in their domestic health sector. On the international plane this found echoes in the policies of structural adjustment pursued by the International Monetary Fund (IMF) and the World Bank whose funding eclipsed that of WHO in the 1990s. Downsizing and sustainability climbed policy agendas in the 1980s, along with

Health Sector Reform. The emphasis on NGOs arose in a climate where public sector health provision was often characterised as inefficient, centralised and unaccountable (Green and Mathias, 1997). In this context there was a growing awareness of the financial capacity of NGOs and their experience in funding systems at a local level. Sollis also points to the heightened media profile of NGOs through their involvement in emergency and disaster relief during the 1980s and 1990s (Sollis, 1992; see also Philo, 1993; Philo, 1999). NGOs also attracted the attention of donors in relation to concepts of good governance and plurality. Industrialised donor countries began to criticise not only the efficiency of recipient states, but also their legitimacy, on the grounds of a lack of democratic process or accountability. They have highlighted the need for a better understanding of NGOs. There is no historical evidence on which to base these claims of accountability (Green and Mathias, 1997, p.15).

WHO had refashioned itself in order to survive the growing influence of new and powerful actors such as the World Bank. Its essential drugs programme in the 1980s had incurred the opposition of the US and American pharmaceutical companies. In the 1990s it set itself up as co-ordinator, strategic planner and leader of global health initiatives working in partnerships with the new players. In part this was in response to the Children's Vaccine Initiative, seen in the organisation as an attempt by UNICEF, the World Bank, the UN Development Programme and other players to wrest control of vaccine development (Brown *et al*, 2006). New mechanisms, institutions and targets emerged with the new actors. New 'hybrid' institutional actors appeared bringing together different combinations of state, market and civil society actors in innovative institutional

arrangements (Lee, Koivulsalo, Ollila, Schrecker *et al*, forthcoming). Since the early 1990s there have been a proliferation of initiatives that bring together state, market and civil society actors; these global public-private partnerships (GPPPs) have focused on specific targets. Key examples are the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI). GPPPs have involved for-profit organisations directly in decision making and the appropriateness of this approach has been questioned (Buse and Walt, 2000; Ollila, 2003; Richter, 2004). Contemporary philanthropic foundations, in particular the Bill and Melinda Gates Foundation, have become major actors in GPPPs. The Gates Foundation is currently among the three biggest donors to global health (e.g. to GFATM, GAVI) (Lee *et al*, forthcoming). New targets have also been set. The UN Millennium Development Goals set eight targets to be met by 2015, including halving extreme poverty and providing universal primary education. According to reports in 2007 progress has been mixed, with few in-roads in some areas, for example in reducing poverty in sub-Saharan Africa (UN, 2007a; UN, 2007b).

Conclusions: Old wine in new bottles ? Strengthening our understanding of GHG

We can see from this overview that many of the themes and issues considered ‘new’ in GHG are hardly the case. In the nineteenth century, the need to mobilise internationally to confront pandemics and epidemics also preoccupied states and conditions of trade and economy were important determinants of the nature of the response. Non state actors and organisations proliferated in influence and in organisation, and so did rapid technological change. The interwar years likewise have much to offer to consideration of the present.

The history of international philanthropy in the interwar years, with the work of Rockefeller and the other foundations, should speak directly to today's assessment of the role of public/private partnerships. The relationships between the LNHO and RF, were in essence a public-private partnership. As Dubin has argued 'They penetrated deeply into national societies drawing domestic administrative, research and educational agencies into a transboundary biomedical/public health infrastructure' (Dubin, 1995, p.73). The dominance of the biomedical paradigm then at the international level is mirrored in today's criticisms of reliance on technical solutions such as vaccination. Other features of the interwar period are worthy of note. It was the 1930s that witnessed the first single issue co-operation between INGOS i.e. in 1932 around 30 international peace and disarmament organisations formed an International Consultative Group to promote 'cooperative action and coordinated policies' (Seary, 1996, pp.21-22).

Globalisation itself should be subject to historical scrutiny. Brown *et al* (2006) have argued persuasively that the focus latterly on the global and on global health governance with its aura of 'newness' was part of WHO's refashioning of itself in the 1990s as coordinator and planner of health initiatives involving the much wider range of key players who had come onto the scene. They see Brundtland's tenure at WHO as key to this repositioning. The term also gained support from interests who had opposed nuclear war and who, as this threat receded in the 1990s, transferred their attention to environmentalism. Some other features of this repositioning, now hailed as new, are also redolent of the past. Take, for instance, the WHO's Framework Convention on Tobacco Control of 2005, or the current moves to develop a similar convention for alcohol.

(Lancet, 2007). These initiatives can be located in the history of international moral and scientific health activism and have their antecedents in the history of international drug control, with its origins in the early twentieth century (Berridge, 2001). The rise, fall and refashioning of terminology always carries with it a broader political significance beyond a simple representation of ‘reality’. It is tempting to see everything as new. This paper has shown that this is not entirely the case: the earlier history of international health governance offers case studies which speak to today’s concerns. We now need to move to a contemporary history, the history of the emergence of the concept of ‘globalisation’ itself and the interests which have supported it.

Notes

1. The Social Section was responsible for the traffic of women and children, the traffic of opium and other dangerous drugs and from 1924 the residual aspects of child welfare not covered by the LNHO and ILO. A separate opium section was created in 1930.

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Year	INGOS* created	Still active at mid 20 th century	IGO** created	Still active at mid 20 th century
1815-49	4	4	1	1
1850-54	1	1	0	0
1855-59	4	1	2	0
1860-64	6	3	1	0
1865-69	9	4	5	3
1870-74	8	6	3	1
1875-79	17	9	2	2
1880-84	11	6	3	2
1885-89	29	16	2	1
1890-94	35	19	3	3
1895-99	38	20	2	1
1900-04	61	22	5	2
1905-09	131	42	4	1
1910-14	112	38	4	3
	466	191	37	20

* International non-governmental organisations

** International governmental organisations

Fig 1. The Development of International Organisations 1815-1914 (source: Lyons, 1963, p.14).