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Global Health, Aid Effectiveness and the Changing Role of the WHO

Wolfgang Hein and Ilona Kickbusch

The fear of pandemics, the significance of health in the fight against poverty, and a proliferation of new actors have increasingly directed international attention towards global health. In this context, the financial resources available for global health as well as the flexibility in problem solving have increased significantly, but at the cost of a proliferation of public and private actors which tends to inhibit the effective use of these resources. The Paris Declaration on Aid Effectiveness has been broadly embraced in global health, and there has been a reappraisal of the coordinating role of the World Health Organization (WHO).

Analysis

Since the 1990s the growing number of actors involved has considerably changed the field of global health governance (GHG). Partnerships between states, international governmental organizations (IGOs) such as the WHO, the pharmaceutical industry, and also civil society organizations have helped overcome conflicts between the profit-driven production of medicines and the health needs of poor countries. However, they have also led to a vast entanglement of responsibilities, with the WHO losing its profile as the central authority on global health. In recent years, however, the impacts of the Paris Declaration on GHG and a number of other processes have again strengthened the position of the WHO:

- Important efforts have been undertaken to improve effectiveness in global health.
- Initiatives at the country level have strengthened support for national health systems.
- At the WHO two binding international agreements have been concluded and are now administered in Geneva: the Framework Convention on Tobacco Control and the (new) International Health Regulations. Increasing the participation of non-state actors through organizational reforms could further strengthen the WHO's role.
- In 2008 the WHA passed the *Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property Rights.* The 2010 WHA discussed proposals to finance this strategy, but adjourned the decision to 2011.
- On May 10, 2010, the Council of the European Union adopted the far-reaching *Conclusions on the EU role in Global Health,* supporting "increased leadership of the WHO at global, regional and country level" and improved access to medicines and health services in developing countries.

Keywords: *global health governance, health partnerships and systems, aid effectiveness, WHO reform*

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1. The Concept of Global Health Governance

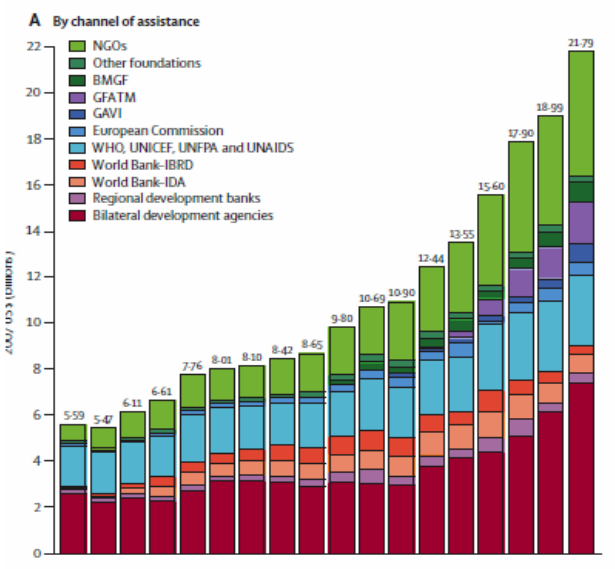
Since the 1990s a proliferation of actors has been observable in the health sector, this has affected GHG even more than similar developments in other fields of global governance. In addition to a growing number of civil society organizations (CSOs), many new types of actors and global initiatives (for example, foundations, public-private partnerships, or the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)) are interacting with national governments and IGOs. The term *global health governance* was introduced into the academic discourse around the year 2000. GHG can be understood as a mechanism for collective problem-solving, that is, health improvements through the interplay of different institutional forms and actors at different levels (see GIGA Focus Global No. 7/2006). Some GHG institutions were explicitly created to sideline IGOs such as the WHO or the World Bank, which were considered too bureaucratic and not sufficiently results oriented.

GHG implies a substantive concern with issues that affect populations worldwide, either directly (for example, the global spread of diseases such as HIV/AIDS and the highly feared new influenza pandemic) or indirectly (extreme inequalities in medical care, unhealthy consumption patterns). The emergence of new actors in global health has not only added expertise and financial resources to the field of international health (see Figure 1) but has also contributed to a higher degree of flexibility in dealing with global health problems.

2. The Importance of Health Partnerships

Global health partnerships (GHPs, frequently used interchangeably with global health initiatives (GHIs)) have contributed significantly to fundamental changes in the architecture of international health policies over the last 20 years. Through the integration of a number of different actors—government health departments, international multi- and bilateral organizations, pharmaceutical enterprises, private foundations, and civil society organizations—in different combinations as required by the specific tasks and the social and political environments, flexible forms of cooperation have become possible. These partnerships combine the specific needs identified by governments, IGOs, or CSOs with the scientific and technological capacities of private corporations and the financial resources of donor countries, public funds, or private foundations.

Figure 1: Development Assistance for Health from 1990 to 2007 by Channel of Assistance



Note: The bar graph represents the contributions of specific (groups of) donors in the same sequence as in the legend. (BMGF: Bill and Melinda Gates Foundation; GAVI: Global Alliance on Vaccines and Immunization)

Source: Ravishankar et al. 2009: 2115.

During recent years, GHPs have made important contributions to research on neglected diseases,[1] to financing for health activities in specific fields such as HIV/AIDS and immunization, and to improving access to medicines in poor regions. However, they also entail a number of problems:

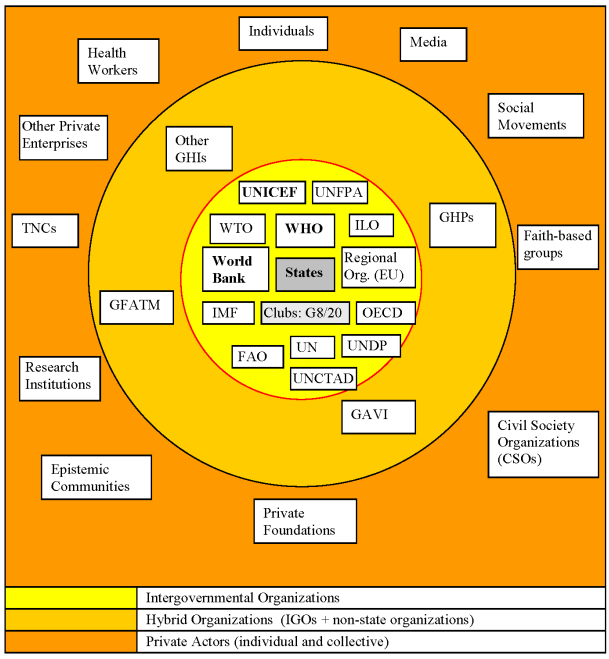
(1) The tendency in global health to focus primarily on controlling and treating specific diseases (in developing countries, the "diseases of the poor") has been reinforced by GHPs. Their activities are linked to a predominantly vertical orientation, that is, a chain of activities focusing on specific diseases and including the identification of pathogens, research and development on medicines and means of treatment, the distribution of medicines, the securing of access to financing and technical infrastructure, and the medical infra-

[1] These are diseases on which expenditures on R&D had been small due to a lack of private incentives for a lack of purchasing power of affected persons or countries.

structure for treatment. Horizontal activities such as improving national health systems and developing primary health care (PHC) systems have been relatively neglected.

(2) There has been a growing critique concerning a lack of legitimacy and accountability on the part of most of the new non-state actors in GHG. Large CSOs, GHPs, and financially strong foundations (such as the Bill and Melinda Gates Foundation) are having an important impact on the orientation of global health without being accountable to the people affected by their activities. While IGOs may also suffer from legitimacy problems, they are clearly accountable to governing bodies in which sovereign states are represented.

Figure 2: Actors in Global Health



Note: Abbreviations (excluding the well-known UN organizations): GHIs: Global Health Initiatives; TNCs: Transnational Corporations; GAVI: Global Alliance for Vaccines and Immunization; UNFPA: United Nations Population Fund.

Source: W. Hein.

(3) International cooperation is becoming more complex. Poor countries are receiving aid from a growing number of different organizations. This has made it difficult for national governments to pursue consistent national strategies to develop their health systems.

3. The Paris Declaration and Its Impact on the Health Sector

After the adoption of the Millennium Development Goals (MDGs) in 2000, the OECD and the World Bank organized a global discourse on the effectiveness of development cooperation. The growing number of international and transnational actors tended to reduce the capacity of developing-country governments to pursue effective national strategies. Particularly in the poorest countries, it appeared difficult to achieve the MDGs without a thoroughgoing reform of international cooperation.

The International Conference on Financing for Development in Monterrey, Mexico (2002) paved the way for a negotiation process which led to the Paris Declaration on Aid Effectiveness (2005). The declaration articulates five target areas of improvement for aid effectiveness: ownership, harmonization, alignment, results, and mutual accountability. Donor countries will coordinate and harmonize their aid in order to effectively support their partners' national development strategies, which will in turn basically follow internationally agreed-upon concepts of good governance. The results of cooperation are jointly evaluated.

By explicitly addressing the problem of the multiplicity of donors in relation to the goal of "delivering effective aid," the Paris Declaration also reacts to the central problems in GHG. For example, during the preparation process for the Accra High Level Forum on Aid Effectiveness (a 2008 follow-up meeting to the Paris conference in Accra, Ghana), the WHO, the World Bank and OECD proposed using health as "'tracer sector' for tracking progress on the Paris Declaration." They pointed out that "aid effectiveness is particularly challenging in health. As with other sectors, difficulties are the result of inefficiencies in the global aid architecture and of poor country policies; however, problems in health are exacerbated by the inherent complexities of the sector itself" (OECD/DAC 2007: 5).

Global health is affected by the Paris-Accra Agenda in all areas which demand country-level coordination. This also includes the national and local coordination of disease-oriented programs. UNAIDS has promoted several coordination activities, of which the concept of the "Three Ones" (2004) is the most important. It aims to establish one agreed-upon HIV/AIDS action frame-

work that provides the basis for coordinating the work of all partners, one national AIDS coordinating authority, and one agreed-upon country-level monitoring and evaluation system (WB/WHO 2006: 15). Related to this, the Country Harmonization and Alignment Tool (CHAT), developed by UNAIDS and the World Bank, was presented in 2007.

4. Health Systems and Primary Health Care

Health has an important place among the MDGs. The health-related MDGs (focused on infectious diseases, maternal health, child mortality, and access to medicines) correspond to the vertical approaches to global health dominant in the 1990s. This vertical approach implied a neglect not only of coordinated support for national health systems but in particular of approaches geared toward the support of marginalized population groups. The slow progress on many health indicators that resulted, in spite of the rapid growth in resources invested, led to the refocusing of health aid on health systems, and particularly PHC, in order to improve the chances of meeting the MDG targets.

The High-level Forum (HLF) on the Health MDGs (World Bank & WHO 2006) held three meetings in 2004 and 2005. "Scaling up aid for health" was the HLF's main goal and implied better coordination between GHPs, the improvement of health funding, and concrete strategies to support the development of health systems in poor countries. "Best practice principles for GHPs" demanded adherence to the Paris Declaration principles and the establishment of an issue-oriented annual forum to be supplemented by more informal liaison and information-sharing between the largest GHPs. The nonalignment of funding with government priorities (50 percent is earmarked for specific diseases or programs), the lack of long-term support, and the volatility of funding were criticized.

The Scaling Up for Better Health (IHP+) Initiative was jointly established by the most important health funders. The IHP+ process is led by the so-called Scaling-up Reference Group (SuRG), which brings together the eight most important agencies/initiatives in global health—WHO, the World Bank, GAVI, UNICEF, UNFPA, UNAIDS, the GFATM, and the Bill and Melinda Gates Foundation—which have as a group gained importance beyond IHP+ under the name Health 8. The group is tasked with providing centralized oversight and coordination of all the initiatives in which the eight agencies participate, for instance, the International Health Partnership, the Catalytic Initiative to Save a Million Lives, the Global Campaign for the Health MDGs, and Providing for Health. The focus of all IHP+ initiatives is on achieving health-related MDG outcomes by increasing aid effectiveness; improving policy, strategy and health systems performance; and mobilizing all actors, including non-state actors. Actions are country focused and country led.

The concept of primary health care was launched by the WHO at the Alma Ata conference in 1978 as a guideline for a comprehensive health policy. It was a core element of the strategy to achieve "Health for All" and has to be seen in the contexts of social, economic, and cultural human rights and of the call for a new international economic order. The importance of community participation and nongovernmental organizations (NGOs) for PHC was particularly highlighted in Africa. In the 1980s the implementation of the PHC concept was hindered by a variety of factors, among them the politics of the Washington Consensus, a shift towards selective PHC and the control of infectious diseases, and the lack of a long-term political and financial commitment to comprehensive PHC. Within the discourses on the MDGs and aid effectiveness in recent years PHC has received renewed attention.

What is the role of non-state actors in promoting health care in poor countries? In a recent meeting of experts on the role of GHPs in low-income countries (Berlin, September 21, 2009), the contribution of the private sector to health systems in poor countries generated acute controversy. Civil society organizations like Oxfam criticized the "myths about private health care in poor countries" as "blind optimism." They view the substantial proportion of private actors in total health care in many poor countries basically as a consequence of state failure.

According to data on India, although the private sector provides 82 percent of outpatient care in the country, 50 percent of women actually have no medical assistance whatsoever during childbirth. Seventy-three percent of private healthcare providers in Malawi are just shops which sell some medicines, while 15 percent are traditional

healers. Upgrading public capacity is more effective than private sector investments.

Other contributors to the Berlin meeting, however, suggested that—in the context of a government-led health program—it may not be so important whether a hospital is run by a private or public operator; however, where it might be difficult to find private investments, for example, for educating more health personnel, public resources. Quality is closely related to the appropriate regulation of the sector, something which is generally accepted as the task of the state. In general, however, it has been agreed that private sector involvement in partnerships should go beyond the traditional involvement in offering health services and participation in product development and access-oriented partnerships. It should focus more on the broader issues in the fields of health financing, such as insurance systems and the instruction of more health-care personnel.

5. The Role of the WHO

Recent developments document the fact that there is broad agreement on the urgent need for more coordination in GHG. Reactions to the Paris Declaration relate to development cooperation, which is only one aspect of global health. There is a need for global health diplomacy in the sense of an authoritative reconciliation of interests and concepts through negotiations and compromises. Is there now a chance to overcome the critical positions of many industrialized countries, as well as of non-state actors, which have weakened the WHO's role in global health since the 1990s?

The WHO was created in 1948 to "act as the directing and co-ordinating authority on international health work" (Constitution of the WHO, Art. 2a). It was entrusted with the task of "establishing and maintaining effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate" (Constitution of the WHO, Art. 2b). The WHO was established as an IGO with three organs: the WHA, the Executive Board and the Secretariat. The Executive Board was originally conceived of as a regionally balanced body of experts technically qualified in the field of health (Art. 24). Its members were to "exercise power delegated to them by the Conference on behalf of the whole Conference, and not as representatives of their respective governments" (Kickbusch, Hein, and Silberschmidt 2010). This was changed in the late 1990s so that the members now also represent their countries. Aside from the addressing of technical matters, WHO negotiations have mostly involved coalition- and bloc-building processes among nations as well as periodic attempts by powerful states to curtail the organization's autonomy—at times bringing the WHO close to paralysis.

These problems have certainly played a role in stimulating new actors to move into the health arena and to search for new institutional arrangements. But to some extent, nation-states themselves have weakened their own organization, particularly through the cap on assessed contributions since the so-called United Nations Reform Act (Helms-Biden Act), a 1999 US law that set a number of conditions for the reform of the UN system before the US would release its total amount of arrears in payment to the UN. This introduced the principle of zero nominal growth into the WHO budget process and forced the organization to be dependent on extra-budgetary resources. This becomes a problem when the WHO is forced to compete for funding with other bodies, NGOs, and even countries: the "steady shift to a competitive model of funding runs the risks *(sic)* of undermining their crucial role as trusted neutral brokers between the scientific and the technical communities on the one hand, and governments of developing countries on the other" (Ravishankar et al. 2009).

In spite of these problems, the WHO has partially regained its central position in recent years. It has increasingly assumed a more active role in global health diplomacy, particularly through the successful negotiation of two important international agreements, the Framework Convention on Tobacco Control (FCTC) and the new International Health Regulations, which played an important role in the coordination of the control of SARS, the avian flu, and the "swine flu" (Pandemic Influenza, H1N1; see: GIGA Focus Global 3/2009).

Furthermore, the WHO has used high-level expert commissions to organize focused discourses on important global health issues. These mostly consist of members representing stakeholders from quite diverse political and cultural backgrounds and are established for a limited period of time to produce substantial reports on top-

ics of far-reaching importance, including influential policy recommendations (similarly to the so-called Brundtland Commission and the Commission on Global Governance).

Three such commissions have been initiated and managed by the WHO since the turn of the century: the Commission on Macroeconomics and Health (CMH), the Commission on the Social Determinants of Health (CSD), and the Commission on Intellectual Property Rights, Innovation and Public Health (CIPIH). These commissions have turned out to be important policy-making tools that help coordinate the multiplicity of actors in GHG by allowing an open discourse between stakeholders with conflicting interests and produce a meaningful focus for the strategic debates and decision making of participating organizations. They can also refer problems which need decisions by state authorities to the WHA.

This new form of activity on the part of the WHO has proven to be particularly important in the field of innovation and public health. Following the publication of the CIPIH's final report in 2006 (CIPIH/WHO 2006), a consensus began to emerge on the need for changes to the global system of innovation for medicines and for health research more generally. This led to the establishment of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property (IGWG) under the auspices of the WHO. The IGWG, open to all interested member states and including civil society actors, was mandated to draw up a global strategy and plan of action. Its aim was to provide a medium-term framework to secure an enhanced and sustainable basis for needs-driven, research and development on essential medicines relevant to diseases that disproportionately affect developing countries. This *Global Strategy* and parts of the *Plan of Action* were adopted in a resolution passed at the WHA in May 2008 (WHA 61.21). The WHA 2010 discussed concepts for financing the *Plan of Action*, which is quite a difficult prospect considering the Taskforce on Innovative International Financing for Health Systems' estimate that by 2015 USD7.4 billion will be necessary annually for funding health research and development. Finally, due to concerns raised by some countries about the task force's approach, a new consultative working group was appointed and the decision adjourned to the next WHA in 2012. Whatever the final result, this process indicates that the WHO is now in a position to lead negations on large-scale funding, whereas the US and other industrial countries insisted on establishing the GFATM outside of the UN system.

In a recent statement, the Council of the European Union (2010) called for support for the "increased leadership of the WHO at [the] global, regional and country level" (conclusion 12). The council also requested "Member States to gradually move away from earmarked WHO funding towards funding its general budget" (conclusion 12) and, concerning intellectual property rights, to "support third countries, in particular LDCs, in the effective implementation of flexibilities for the protection of public health provided for in TRIPs agreements, in order to promote access to medicines for all" (conclusion 16a). Furthermore, the council called "on the EU and its Member States to promote effective and fair financing of research that benefits the health of all" and demanded exploratory models in relation to the WHO's *Global Strategy and Plan of Action* (conclusion 18).

6. Adapting the WHO to GHG through Institutional Reforms

As the world's primary health authority, the WHO has a responsibility to safeguard public interests in conflicts on global health and is the only legitimate entity for setting a central agenda for governing global health. None of the coordination mechanisms mentioned thus far has the same obligation to serve the public interest, to demonstrate fairness in decision making, and to act in a completely transparent matter.

Lawrence O. Gostin, professor of international law, has proposed that the WHO take full advantage of its treaty-making capabilities and establish a Framework Convention on Global Health that bindsall major stakeholders (states as well as non-state actors) to the aims of building capacity, setting priorities, coordinating activities, and monitoring progress. He feels that global health efforts ought to be shifted to focus on basic survival needs, something which would require the coordinated political and financial commitment of all relevant actors (Gostin 2007).

A second proposal focuses on the importance of the WHA (Kickbusch, Hein, and Silberschmidt 2010). For a productive coordination process leading to the "harmonization of conflicting strategies" and reaching beyond a clash of fixed positions,

the WHO should be in a position to make much better use of the processes of nodal governance, which allow continuous interaction in the respective fields between basically all actors concerned. The WHA ensures the interface between the delegates of its members (nation-states) as well as the interface of these delegates with the representatives of many other global health actors. Quite independent from what is being discussed on the assembly's formal agenda, the new "polylateral diplomacy" (Wiseman 1999, note 10) is conducted throughout the WHA: Formal and informal meetings take place, agreements are reached, deals are struck, NGOs exert influence, the private sector lobbies, receptions are organized. In short, key global health players participate in the assembly even if they are not part of the formal meetings.

The Constitution of the World Health Organization has not yet been fully leveraged as a vehicle for global health governance. As the only legitimate supranational authority on health issues, the WHO is the appropriate vessel for housing a centralized coordination mechanism that brings all prominent global health actors to the table for harmonized agenda setting and decision making.

As such, it has been recommended that a Committee C of the WHA be established, which—in addition to member-state representatives—involves the active participation of international agencies, philanthropic organizations, multinational health initiatives, and representatives from major civil society groups, particularly those who legitimately represent the most vulnerable populations. The work of such a group would complement the current Committee A's program focus and the budget and managerial responsibilities of Committee B.

The proposed Committee C would debate major health initiatives and provide an opportunity for the primary players involved in health to present their plans and achievements to, and discuss collective concerns with, the WHA's member-state representatives. The committee would then pass resolutions just like the other committees and would be bound by rules of procedure and implementation that respect the mutual sovereignty of all parties.

Nongovernmental organizations such as World Vision, as well as some WHO member states, have introduced this concept together with other proposals for better global governance into the informal discussions around WHA 2010. The incoming chair of the WHO Executive Board echoed this call in his acceptance speech. He drew attention to the fact that the board needs to pay more attention to global-level issues which require effective global governance. He indicated that this also means that other actors in health have to become more accountable, and that he sees proposals like that for establishing a Committee C—intended to channel the voice of these health actors as part of the WHA deliberations—as worthy of further consideration. It seems that there is general agreement that the time has come for a constructive debate, within the WHO governing bodies as well.

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Related GIGA Research

Research on global health governance is part of the GIGA's Power, Norms and Governance in International Relations research program. After completing a conference and publication project entitled "Making Sense of Global Health Governance," the program is now preparing the following research projects: "The Role of Private Foundations in Global Governance: The Cases of Health and Education" and "Primary Health Care as a Systemic Approach to Improve Health Service Provision in Africa." The GIGA was also a partner in the research project "Ethical Governance of Biological and Biomedical Research: Chinese European Cooperation" (Ole Döring; European Commission Sixth Framework Programme), which was completed in October 2009.

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