

D I . I The global health landscape

The last few years have been good for 'global health'. Everyone talks about it. Large amounts are spent on it. Many universities have created departments of global health. The prominence of health indicators among the Millennium Development Goals also shows the ascendancy of 'global health' in international affairs. Even Hollywood celebrities fly the 'global health' flag.

The need to 'govern' health at a global level is important for several reasons. For a start, health care itself has become 'globalised'. Health workers are imported and exported from one country to another. Tele-medicine, medical tourism and the number and size of multinational medical enterprises are expanding. The Severe Acute Respiratory Syndrome (SARS) epidemic, multi-drug-resistant tuberculosis and the threat of a lethal global flu pandemic have further focused attention on global health governance and the need for laws, guidelines and standards to optimise disease control across national borders. Finally, many of the underlying determinants of poor health are global in nature. The effects of the globalised economic system on poverty and nutrition, as well as climate change, all point to the need for strong and effective global health leadership.

Meanwhile, a raft of new organisations, institutes, funds, alliances and centres with a 'global health' remit have mushroomed, radically transforming the 'global health landscape', raising questions about the accountability, effectiveness and efficiency of global health governance.

Development assistance for health and global health partnerships

Development assistance for health (DAH) has increased dramatically. According to the World Bank it rose from US\$2.5 billion in 1990 to almost US\$14 billion in 2005 (World Bank 2007). Most of this increase has come

from official donor country aid. But new sources of global health financing, in particular the Gates Foundation, have been significant. Private funding now accounts for about a quarter of all development aid for health (Bloom 2007). In sub-Saharan Africa, external health sector funding accounts for 15 per cent of all health spending on average, and a much higher proportion of public health financing (World Bank 2007).

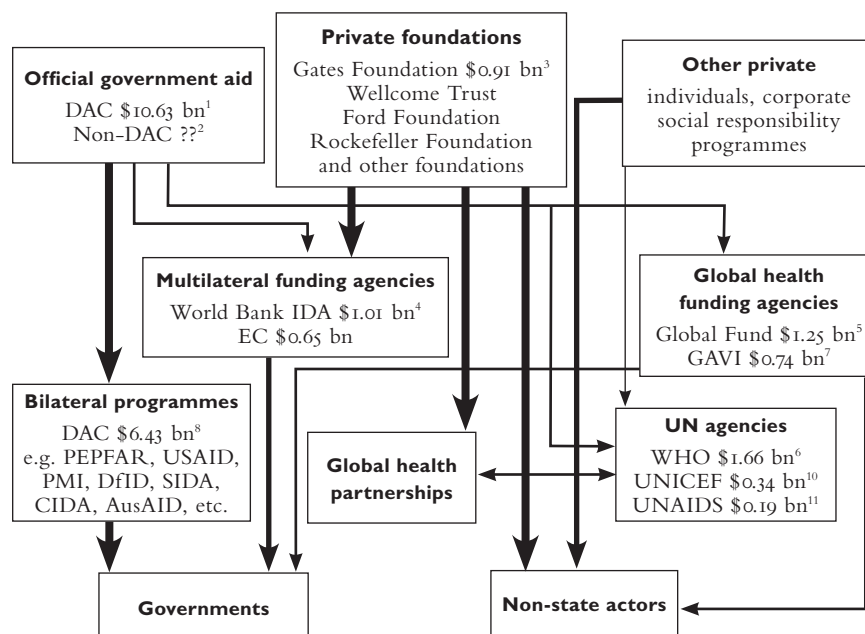
There are three main sets of sources of DAH (see Figure D1.1). The first is official government aid, mainly from member countries of the Development Assistance Committee (DAC) of the OECD. In 2006, DAC countries collectively disbursed \$10.6 billion for health assistance, of which the United States contributed approximately half. The US proportion of aid increased in 2007. The amount of non-DAC aid for health to low- and middle-income countries is not known because of a lack of available data. For example, China, which has increased its development assistance budget in recent years, provides few data on where and what this money is spent on.

The second set comprises private foundations, and in particular the Gates Foundation. In 2006, the Gates Foundation awarded 195 global health grants totalling US\$2.25 billion. Finally, funding is also provided by individuals, typically through donations to international humanitarian and health-related organisations and charities, as well as by businesses, often through what are called 'corporate social responsibility' programmes.

The recipients of DAH can be broadly grouped into four sets of actors. The first group consists of recipient-country governments. The second consists of a variety of non-state actors involved in providing health services at country level, including non-governmental organisations (NGOs), faith-based organisations and a variety of health research organisations. The third group consists of UN agencies such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). And the final group consists of what are called global health partnerships (GHPs), many of which are relatively new.

Some DAH is channelled directly from donor to recipient. For example, donor governments may channel their funding to recipient governments or NGOs directly through bilateral programmes of aid; the Gates Foundation makes many grants directly to NGOs and research organisations. Some DAH, however, is channelled through multilateral agencies or new global health financing agencies such as the Global Fund to Fight AIDS, TB and Malaria (GF) and the GAVI Alliance.

Figure D1.1.1 illustrates a summarised version of the complex and convoluted global health aid architecture. However, each box listed in the contains a much bigger number of separate actors and institutions.

FIGURE DI.1.1 Overview of global funding in health in 2006**Notes**

1. Current bilateral and multilateral disbursements (gross) for health and population programmes by DAC countries in 2006. The commitment of US\$1.01 billion to the World Bank has been added to this figure. The total current commitments (gross) for 2006 are \$13.64 billion.
2. A figure for 2006 is not available. However, for comparison, non-DAC countries total ODA (net) for 2005 was \$3.23 billion. Note that health-sector spending will be a small fraction of this figure. The list of non-DAC countries does not include China (see the World Bank Development Indicators 2007 for more details: http://siteresources.worldbank.org/datastatistics/Resources/table6_11.pdf).
3. Grants paid for global health in 2006. The commitments made in 2006 are much larger at \$2.25 billion (www.gatesfoundation.org/GlobalHealth/Grants/default.htm?showYear=2006).
4. Current commitments (gross) for health and population programmes by Development Assistance Committee (DAC) countries via the World Bank in 2006. Data for disbursements in the health sector alone were unavailable.
5. Current disbursements (gross) for health and population programmes by DAC countries via the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2006. The current commitments (gross) for 2006 are \$1.73 billion.
6. Current disbursements (gross) for health and population programmes by DAC countries via the European Commission in 2006. The current commitments (gross) for 2006 are \$0.51 billion.
7. Cash received by the Global Alliance for Vaccines and Immunisation in 2006. Annual disbursements were unavailable.
8. Current bilateral disbursements by DAC countries in 2006. The cash received by GAVI from DAC countries of \$0.74 billion has been deducted for the purposes of the overview – it is included in the OECD figures as ‘bilateral assistance’.
9. Half of the WHO proposed programme budget for 2006 and 2007.
10. Current disbursements (gross) for health and population programmes by DAC countries via UNICEF in 2006.
11. Current disbursements (gross) for health and population programmes by DAC countries via UNAIDS in 2006.

Sources: OECD 2008; Gates 2006; GAVI 2008; WHO 2006.

According to the UK government, global health assistance is now ‘over-complex’, and includes 40 bilateral donors, 26 UN agencies, 20 global and regional funds and 90 global health initiatives (DFID 2007). In addition, international NGOs such as Médecins Sans Frontières, Oxfam, Save the Children, International Planned Parenthood Federation, Care International and CAFOD have become bigger, more numerous and more important to health-care delivery in low-income countries (LICs).

At the global level, the new actors have caused a crisis of identity for many of the more established actors such as the WHO, UNICEF and the World Bank and the bilateral donor agencies. The adoption of narrow results-based performance measures have also led some global health initiatives to pursue their objectives without enough consideration of the impacts of their activities on the wider health system or the wider aid system. The chase for funding, success and public attention undermines efforts to ensure a more organised system of mutual accountability, coordination and cooperation (Buse and Harmer 2007).

The competitive and uncoordinated global environment results in expensive transaction costs for ministries of health having to deal with so many partners and having to manage fragmented health provision and competing for the limited numbers of trained staff. Zambia, for example, has major support from fifteen donor agencies, all of which demand separate reports, meetings and time from government officials. Bilateral donor channels often run outside Zambia’s efforts to coordinate a sector-wide approach to health systems development.

According to the World Bank, ‘never before has so much attention – or money – been devoted to improving the health of the world’s poor’; but it warns that ‘unless deficiencies in the global aid architecture are corrected and major reforms occur at the country level, the international community and countries themselves face a good chance of squandering this opportunity’ (World Bank 2007).

The ninety or so global health initiatives come in different shapes and sizes. Some have been established as global health financing agencies (e.g. the Global Fund and the GAVI Alliance); some have been established to provide coordination around efforts related to a particular disease or health issue (e.g. the Partnership for Maternal, Newborn and Child Health; Stop TB; Roll Back Malaria; the Global Health Workforce Alliance); while many others have been established to improve the availability of medicines, vaccines and other health technologies (e.g. the Medicines for Malaria Venture; the Alliance for Microbicide Development; the International AIDS Vaccine Initiative). Sixteen of these GHPs have been described in brief in Table D.1.1.1 to illustrate the different types of GPP and their complex configurations.

TABLE DI.1.1 **Summary of selected GHPs**

GHP	Major partners	Purpose of partnership	Main funders
Alliance for Microbicide Development	American Foundation for AIDS Research, AIDS Vaccine Advocacy Coalition, Family Health International, Gay Men's Health Crisis, Global Campaign for Microbicides, Global Microbicide Project, International Family Health, International Partnership for Microbicides, National Organizations Responding to AIDS, WHO	Advocate for and support microbicide development	International Partnership for Microbicides, Rockefeller Foundation, Gates Foundation, other foundations, ODA
Aeras Global TB Vaccine Foundation	More than fifty IGOs, universities, biotech and pharmaceuticals companies, vaccine manufacturers, foundations, advocates and governments	Develop new vaccines against TB and ensure availability to all who need them	Gates Foundation, ODA
Global Alliance for the Elimination of Lymphatic Filariasis	More than forty IGOs, universities, biotech and pharmaceuticals companies, vaccine manufacturers, foundations, advocates and governments	Advocate for and fund the development and provision of technologies and services to treat and prevent lymphatic filariasis	Gates Foundation, ODA
Global Alliance for Improved Nutrition	Tetra Pak, World Food Programme, Danone, UNICEF, Cargill, WHO, Helen Keller International, Micronutrient Initiative, National Fortification Alliance, Unilever, World Bank Institute	Reduce malnutrition through food fortification and other strategies to improve nutritional health of at-risk populations	Gates Foundation, ODA
Global Alliance for TB Drug Development	GlaxoSmithKline, Bayer, RTI International, Stop TB partnership	To develop and ensure the availability of affordable and better TB drugs	Gates Foundation, Rockefeller Foundation, bilateral donors, DFID
Global Alliance for Vaccines and Immunisations	UNICEF, WHO, World Bank, civil society organisations, public health institutes, donor and implementing country governments, Gates Foundation	Promote the development of new vaccines and expanded coverage of existing vaccines	International Finance Facility, Gates Foundation, ODA

GHP	Major partners	Purpose of partnership	Main funders
Global Fund to Fight AIDS, Tuberculosis and Malaria	UNAIDS, WHO, World Bank, Stop TB, Roll Back Malaria, bilateral donors, recipient governments, Gates Foundation, CSOs and business sector	Finance HIV/AIDS, TGB and Malaria programmes in low- and middle-income countries	Gates Foundation, ODA
International AIDS Vaccine Initiative	Over twenty partners from different sectors	Develop an HIV/AIDS vaccine	Gates Foundation, New York Community Trust, Rockefeller Foundation, World Bank, corporate donors, other foundations and charities
International Trachoma Initiative	Over thirty partners from different sectors including universities, foundations, governments, advocates and IGOs	Support the treatment and prevention of trachoma worldwide	Gates Foundation, pharmaceuticals corporations, Rockefeller Foundation, ODA
Mectizan Donation Programme	African Programme for Onchocerciasis Control; the Carter Center River Blindness Program; CDC; Helen Keller International, International Eye Foundation; Merck, Pan American Health and Education Foundation, pharmaceuticals corporations, SightSavers International, UNICEF, World Bank, WHO	Provide administrative oversight of the donation of Mectizan by Merck for the treatment of onchocerciasis	Merck, GlaxoSmithKline
Medicines for Malaria Venture	Africa Matters Ltd, Hospital Clinic Universitat de Barcelona, GlaxoWellcome, Program for Appropriate Technology in Health, Medicines for Malaria Venture, European and Developing Countries Clinical Trials Partnership, Oswaldo Cruz Foundation, Gates Foundation, Tsukuba Research Institute, Global Forum for Health Research	Develop new malaria treatments	Gates Foundation, Rockefeller Foundation, ODA, pharmaceuticals corporations, IGOs, US National Institutes of Health, Wellcome Trust

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GHP	Major partners	Purpose of partnership	Main funders
Pediatric Dengue Vaccine Initiative	WHO, UNICEF, UNDP, US Army and Navy, CDC, NIH, Mahidol University in Bangkok, Pedro Kouri Tropical Medicine Institute in Havana, Ministry of Public Health in Thailand, Taiwan CDC, and other ministries of health in Southeast Asia and the Americas, Sanofi Pasteur, GlaxoSmithKline, Hawaii Biotech	Develop dengue vaccines and diagnostics	Gates Foundation, Rockefeller Foundation
Roll Back Malaria	UNICEF, UNDP, WHO, World Bank, ExxonMobil, GSK, Alternate, Novartis, BASF, Gates Foundation, UN Foundation	Enable sustained delivery and use of effective programmes through coordination, evaluation and advocacy on behalf of partners	World Bank, GFATM, BGMF, ODA
Stop TB	WHO is the main partner. Another seven hundred partners including IGOs, universities, biotech and pharmaceuticals companies, vaccine manufacturers, foundations, advocates and governments	Eliminate tuberculosis as a public health problem through coordination in prevention, treatment and advocacy	WHO, ODA
Global Health Workforce Alliance	WHO plus a hundred partners including IGOs, universities, foundations, advocates and governments	Identify and implement solutions to the health workforce crisis.	WHO
Partnership for Maternal, Newborn and Child Health	WHO, World Bank Group, UNICEF, ODA plus over 240 partners including IGOs, universities, foundations, advocates and governments	Provide a forum coordinating action to address the major conditions that affect children's health	WHO

While the new global health initiatives have raised the profile of certain diseases, and helped develop new technologies for many neglected diseases (often through effective brand-building exercises, good public relations and the allocation of resources to advocacy and communications), the recognition that there has been too much poor coordination, duplication and fragmentation has led to a number of initiatives aimed at improving harmonisation and supporting country-led development. These include the 2005 Paris Declaration on Aid Effectiveness; the Three Ones Agreement (to encourage all agencies addressing HIV/AIDS to work through one action framework, one national coordinating authority and one monitoring and evaluation system); and the International Health Partnership (IHP) initiative launched by the UK government in 2007 to improve coordination around country-driven processes of health-sector development.

Since July 2007, eight international organisations have also been meeting to develop a framework for coordination and to define more clearly their respective roles and responsibilities (UNICEF 2007). The group, known as the 'Health 8', comprise the WHO, Global Fund, Global Alliance for Vaccines and Immunisation, United Nations Population Fund, World Bank, UNAIDS, UNICEF and the Gates Foundation. While these initiatives are welcome, the problems of poor coordination by donors and external agencies have been present for many years, and the prospect that these new initiatives will be successful is poor for three reasons.

First, there are simply too many global health actors and initiatives – better coordination and a truly country-driven approach to health improvement will require a radical rationalisation and shrinkage of the global health architecture. Second, consensus on a coherent health systems development agenda is missing. Third, there is inadequate monitoring of the policies and actions of donors and GHPs – they are largely immune from scrutiny or censure.

The lack of a shared understanding or vision for health systems strengthening (HSS) is discussed in greater detail in Chapter B1. The point to stress in this chapter is that health systems have actually been weakened by the way in which global health programmes and policies are organised and orientated. There is some recognition of this to the extent that most global health institutions are now stressing the importance of 'health systems strengthening'. However, behind the rhetoric are a lack of clarity and even contradictions within and between global health institutions about what constitutes 'health systems strengthening'.

It is, for example, unclear where organisations and GHPs stand on the role of public institutions and markets within the health sector. There is no clear or shared view on the circumstances under which for-profit

and not-for-profit providers should be encouraged or discouraged, nor any policy guidance on how countries should respond to the problems associated with health-care commercialisation. Long-term strategies to strengthen the administrative and stewardship capacities of ministries of health remain either absent, under-resourced or undervalued. Without a detailed analysis of how vertically organised selective health programmes will support across-the-board (horizontal) HSS plans, the glib and opaque notion of 'diagonalisation' has been promoted.

Furthermore, the lack of leadership and policy coherence around a HSS agenda among the big global health actors operating out of Geneva, Washington, London and Seattle is only a little better than the prospect of bad leadership and policy. As discussed in the chapter on the World Bank, there is a worry that the same neoliberal thinking that helped to decimate health systems in many countries in the 1980s will prevail into the future.

Finally, what is also glaring is the lack of meaningful debate on two critical policy tensions. The first is between strategies needed to respond immediately and urgently to preventable and treatable adult and child deaths in poor countries and the longer-term strategies required to strengthen health systems. The second is between a predominantly clinical and technicist approach to disease and illness and a more developmental and holistic approach to health improvement.

Accountability and inappropriate partnerships

A major feature of the changing global health landscape has been the promotion of the 'public-private partnership paradigm' since the 1990s, based on the argument that international cooperation in today's globalised world can no longer be based primarily on the multilateralism of nation-states. Partnerships involving business organisations and civil society are required to achieve what governments and the UN cannot manage alone (Martens 2007).

Although this new approach coincided with a period of zero real growth and real budget cuts to the UN, which was forced to seek supplementary funding from the private sector and fulfil its mandate through partnerships with other organisations, the theory was that public-private partnerships occupy a middle ground between markets and states, permitting 'more nuanced and potentially more effective policymaking' (Kaul 2006). Although reference is often made to partnerships with civil society, the main focus of attention has been on partnerships between intergovernmental organisations (IGOs) and business/industry.

Within the health sector Gro Harlem Brundtland strongly encouraged public–private partnerships during her tenure as director-general of the WHO. The Rockefeller and Gates foundations were also instrumental (Widdus 2003). The Rockefeller Foundation, for example, helped establish the Initiative on Public Private Partnerships for Health (IPPH), which promotes international public–private partnerships in the health sector. And many global health partnerships (GHPs) rely almost entirely on the Gates Foundation for funding, or list it as a major donor.

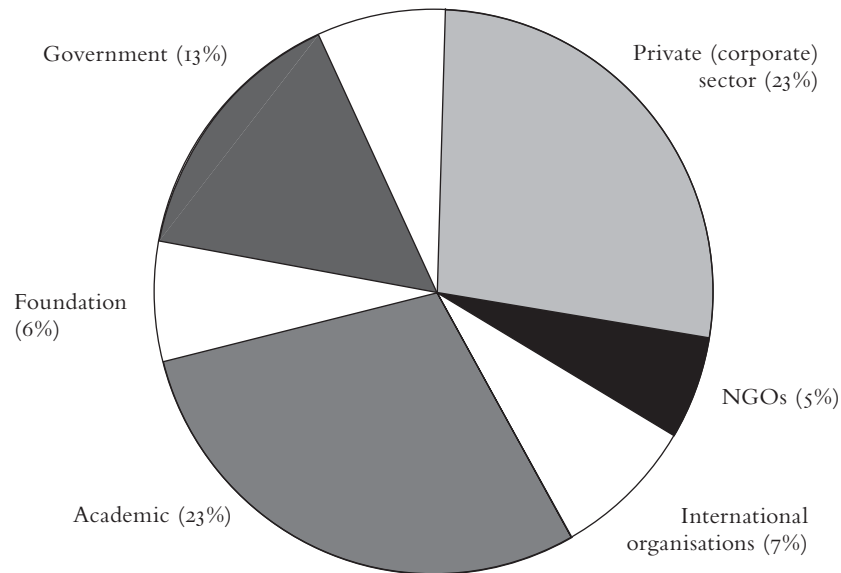
In addition to the issues raised earlier of coordinated and more effective DAH, the new global health landscape raises political issues about the accountability of global health actors and global health governance.

While partnerships are good in principle, there must be an appropriate framework of principles guiding their development and ensuring that the integrity, authority and capacity of public bodies to carry out their public functions are maintained (or developed where necessary). Partnerships must reflect an appropriate spread of power, roles and responsibilities across the public, private and civic sectors.

Presently, the balance of power between public institutions, business and civil society appears skewed in favour of the corporate sector. Globalisation, economic liberalisation and the growth in wealth of multinational corporations require the existence of global public health institutions that are able to ensure appropriate regulation of commercial behaviour to protect health.

One concern is that the public–private paradigm has diminished global public responsibility and allowed businesses to wield undue influence (Buse 2004). Civil society organisations (CSOs) have pointed out fundamental conflicts between commercial goals and public health goals, and a lack of stringent guidelines to govern public interaction with the commercial sector. According to Wemos, ‘industry partnerships and industry sponsorship without strong, enforceable, accountable and transparent guidelines for these relationships will undermine and destroy the WHO’s role and responsibility’ (Wemos 2005).

The imbalance of power is exemplified by an analysis conducted by Buse and Harmer of the composition of the boards of twenty-three selected GHPs (see Figure D1.1.2). Out of a total of 298 board seats, the private (corporate) sector occupied 23 per cent; academic and NGO representatives occupied 23 per cent and 5 per cent respectively; and international and government representatives occupied 20 per cent. The WHO was found to be significantly under-represented at the board level of the most important partnerships (Buse and Harmer 2007). Overall, low- and middle-income countries account for 17 per cent of all seats.

FIGURE DI.1.2 **GHP board analysis**

Source: Buse and Harmer 2007.

A notable imbalance not represented in the figure above is the huge influence wielded by the Gates Foundation. It is on the board of all the major GHPs as well as being a major funder. But, unlike the WHO, it is free of any form of democratic or political accountability.

These findings raise a number of questions. Why is the private (corporate) sector so well represented, especially when its financial contribution is so modest? Why are publicly mandated institutions, such as the WHO, under-represented? On this evidence, the WHO is clearly underpowered to hold its private partners to account where it matters most – at the decision-making level. Why is NGO representation limited? And while global public–private initiatives (GPPIs) give the impression of equal rights for stakeholders and broad representation, in practice it is the wealthy actors from the North that dominate, whether they are governments, corporations or private foundations (Martens 2007).

In theory, GHPs concerned with health in LICs should be accountable to the governments and people of low-income countries. In practice, the under-representation of Southern stakeholders in governance arrangements, coupled with the Northern location of most GHP secretariats, is reminiscent of imperial approaches to public health. While the broken health systems of

many poor countries lie in a state of disrepair, a vast global health industry operating a loosely connected portfolio of initiatives and programmes exists to help the poor. But the poor themselves and the public institutions of the South are mostly invisible as real partners.

In addition, many governments lack the skills or inclination to provide effective stewardship over their countries' health systems. Universities, NGOs and the local media may also be underdeveloped and unable to perform an effective watchdog role over both the government and the international aid industry.

If one steps back to take a panoramic view of the global health landscape, one might even conclude that, while purporting to do good for the world's poor, the global health apparatus not only helps to excuse a global political economy that perpetuates poverty and widens disparities, but also benefits the corporate and rich world through 'bluewashing' (the lending of credibility by the UN) and the opportunity for companies to establish new markets in medical products with minimal commercial risk, while improving access to public and academic expertise and to governments. Bull and McNeill's (2007) investigation into GHPs concluded that 'there are some examples of behaviour by the big pharmaceutical companies which appear to be altruistic, but also many cases in which the companies have enjoyed the benefits of an expanded market without contributing to bringing the prices down.'

Final comments

Many of the radical changes to the global health aid architecture remain inadequately described and evaluated. More work is needed to understand the changes taking place and to enable a more informed and critical discussion. While this chapter deals specifically with 'health', it also reflects on global governance more generally, and on the role of the United Nations, the corporate sector and others in managing the challenges of social and economic development worldwide. The chapter draws out three suggestions for action by civil society.

The first concerns the need for effective and accountable global health leadership. It is possibly a good thing that the 'Health 8' has been formed – hopefully it will lead to a clearer delineation of roles and functions and better coordination. But it is unclear who is ultimately responsible for bringing order to the chaotic environment and how the key actors will be effectively held to account.

Better leadership should also produce a more rational system of development assistance for health. The current system is too fragmented, competitive and top-down. It does not place a premium on country-based plans and

strategies. The principle of the International Health Partnerships is sound and must be supported, but this will require strategies to develop the capacity of ministries of health to provide effective stewardship and improved systems for holding both external agencies and governments to account.

There are also particular implications for the WHO, the World Bank and the Gates Foundation. In theory, the WHO has the mandate and legitimacy to provide the much-needed global health leadership. In practice, its funding arrangements and its reluctance to assume more leadership prevent it from doing this. The challenge facing civil society and the WHO in ensuring more effective public and accountable leadership in global health is discussed in Chapter D1.2. The World Bank, no longer the dominant player on the field, has an important role to play as a bank. But its democratic deficiencies, neoliberal instincts and record of poor and biased research do not make it an appropriate institution for global health leadership. The Gates Foundation is arguably the dominant player currently. But it lacks transparency and accountability, and, as described in Chapter D1.3, it has become an over-dominant influence.

There is no simple solution to the challenge of knitting together the approaches, ideologies and agendas of the different actors. But civil society organisations need to generate more debate and discussion about global health leadership and accountability.

The second issue, related to the first, is the need for a coherent health systems development agenda. This must include the strengthening of public health systems and their absorptive capacities. There is a special need to examine and challenge the ongoing promotion of market-based solutions to health systems failures. Independent and critical assessments of the major global health initiatives and their impact on health systems within low-income countries are badly needed. Health systems policies that are consistent with the principles and logic of the 1978 Alma Ata Declaration need to replace the top-down, disease-based and neoliberal policies that are currently prevalent.

Low-income countries already struggle with a narrow policy space due to globalisation and dependence on external donors. Their policy space is shrinking even further as aspects of health that are characterised as 'global public goods' come to be increasingly 'managed' from the outside by global institutions. The lack of coordination among global health actors currently undermines efforts to ensure effective national health stewardship. However, externally supported health programmes have the potential to support the double aim of improving access to health care *and* contributing to the social, political and systems-wide changes that are required to sustain health improvements.

The third issue concerns the public–private paradigm. There are good reasons for thinking that the present distribution of risk and benefit across the public and private sectors are skewed in favour of the private sector, and that the current partnership models are inefficient. The UN should conduct a comprehensive review of the entire public–private paradigm. Specifically, the WHO needs to monitor and set up transparent regulatory mechanisms of GHPs.

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