Governing Global Health

How better coordination can advance global health and improve value for money

David E. Bloom

HEALTH problems have never respected borders. Leprosy spread from Asia to Europe in the 4th century B.C., thanks most likely to the army of Alexander the Great. The Black Death originated in Central Asia and subsequently ripped through Europe and the Middle East in the 1340s. Diseases carried across the Atlantic by European invaders decimated native populations in the Americas in the 17th and 18th centuries.

Health threats have become increasingly global in modern times. In 1918–19, the Spanish flu took an estimated 50–100 million lives—more than all those killed in World War I. And these days, the ever-greater integration of economies makes it that much easier for diseases, such as HIV/AIDS, to cross borders and leap continents. Moreover, some argue that if avian flu makes the jump to human-to-human transmissible form, the rapidity of its spread could be devastating.

Exacerbating matters, ill health can be spread through other spillovers of globalization. For example, climate change—driven largely by industrial expansion in the West and emerging markets—promotes desertification and drought (which result in food shortages and malnutrition) and will likely result in population movements (which could have a major impact on health). And national or regional economic policies, such as agricultural subsidies to European and U.S. farmers, hamper the prospects for developing world farmers to climb out of poverty and shrug off the diseases that are strongly associated with poverty and inequality.

As the health system has become more global, new players have altered its shape. Private funding, once relatively insignificant, now accounts for nearly one-fourth of all development aid for health. For example, the Bill & Melinda Gates Foundation has emerged as the dominant player in that sector (see

An employee of an Indonesian pharmaceutical company holds pills used to treat HIV patients.

Table 1), with its expenditure accounting for nearly 65 percent of all private aid, worldwide, for health—and equal to more than half of the expenditure of the World Health Organization (WHO), to which essentially all countries belong. It is perhaps noteworthy that much Gates funding goes toward technology development (for example, new drugs and vaccines) that will ultimately translate into new ways of providing direct services.

These new actors have dramatically increased the funds available for investment in global health. But depending on such institutions is risky. Private philanthropies are not accountable to the public, and their decisions may not be in line with the most urgent (or the long-term) needs of recipient countries. If their programs are ineffective, if resources decline, or if interest diminishes, recipient countries dependent on such funds may be left in the lurch.

At the same time as private philanthropy has increased, a plethora of financing bodies, bilateral donors, multilateral organizations, and business groups dedicated to tackling global health threats have emerged or expanded. Like private donors, these groups are also not necessarily fully accountable to the public; often they respond only indirectly to nationally perceived needs. Bilateral donors contributed more than $8 billion in 2005 to public health, with six countries—the United States, Japan, the United Kingdom, Germany, France, and Canada—accounting for about 80 percent of the funds (see Table 2). Most industrial countries are still well below the UN target of devoting 0.7 percent of gross national income to official development assistance; the portion going to health varies widely.

Is the current system of health governance adequate to oversee the changing array of players and ensure that the right health issues are being tackled fairly, effectively, and efficiently? The answer appears to be no. New diseases have come to the fore, and many countries (including some relatively poor ones), at least partway through the epidemiological transition from infectious to chronic diseases, are experiencing a twin burden: they still have high morbidity and mortality from the traditional diseases of poverty, but also face obesity, diabetes, lung cancer, and heart disease. What, if anything, can be done to amend and strengthen current governance arrangements so that they more adequately respond to the challenges at hand? This article examines the successes and failures of the current system of global health governance and suggests the beginnings of a way forward.

Table 1

Private philanthropy

Gates leads by a long shot the top 10 U.S. foundations awarding international health grants.

(2005, million dollars)

Bill & Melinda Gates Foundation	895
Ford Foundation	24
Rockefeller Foundation	22
David and Lucile Packard Foundation	18
William and Flora Hewlett Foundation	13
John D. and Catherine T. MacArthur Foundation	10
Merck Company Foundation	10
Bristol-Myers Squibb Foundation, Inc.	10
ExxonMobil Foundation	9
Starr Foundation	8

Source: The Foundation Center.
Note: International grants include cross-border grants and grants to U.S.-based international programs.

Global health achievements

Over the past few decades, the global health governance system has recorded a number of successes. It should be noted here that by *governance* we mean the manner in which governments, the private sector, and civil society make and implement decisions to promote and protect good health. As such, it includes not only the roles of public and private organizations, but also the formal and informal rules and traditions through which these institutions relate to each other and to the people whose health they seek to defend. Governance also encompasses fostering the exchange of information—about actions and strategies that have proved successful and about those that have not worked.

The most prominent of the successes relate to efforts to control specific diseases, but other programs have also been very important.

Combating specific diseases. Global immunization campaigns have eradicated smallpox, controlled the spread of severe acute respiratory syndrome (SARS), and almost eliminated polio. What was the key to their success? The SARS campaign is illustrative. Although the disease initially took the world by surprise, concerted action after the virus spread beyond East Asia quickly brought it under control. The

Table 2

Country giving

A few countries account for most official international aid for health, with some donors focusing more on health than others.

	Bilateral ODA[1]	ODA percent of GNI	ODA to public health[1,2]	Percent of ODA to public health[2]
United States	26,081	0.22	3,636	13.9
Japan	15,116	0.28	1,156	7.6
United Kingdom	7,187	0.47	729	10.1
Germany	9,122	0.36	593	6.5
France	10,012	0.47	394	3.9
Canada	1,915	0.34	380	19.8
Netherlands	3,872	0.82	318	8.2
Sweden	1,947	0.94	266	13.7
Norway	2,048	0.94	243	11.8
Belgium	1,379	0.53	142	10.3
Denmark	785	0.81	131	16.6
Spain	968	0.27	127	13.1
Ireland	483	0.42	122	25.3
Switzerland	1,477	0.44	84	5.7
Luxembourg	222	0.86	54	24.2
Greece	207	0.17	33	15.8
Austria	1,246	0.52	24	1.9
New Zealand	217	0.27	18	8.4
Australia	1,440	0.25	14	1.0
Portugal	251	0.21	13	5.1
Total	**85,976**	**0.33**	**8,475**	**9.9**

Source: http://stats.oecd.org/wbos/default.aspx.
Notes: ODA = official development assistance. GNI = gross national income. Italy and Finland are not included because data on ODA to public health are unavailable.
[1]Million 2005 dollars.
[2]Public health is the sum of health, population policies/programs and reproductive health, and water supply and sanitation defined at www.oecd.org/dataoecd/44/45/35646083.pdf. This column includes core HIV aid (code 13040) but not social mitigation of HIV/AIDS (section 16064).

WHO, the centerpiece of our system of global health governance, worked closely with national health authorities and was key to this success. Given the global threat, agencies put aside their competing interests and coordinated their efforts through the rapid establishment of global epidemiological, clinical, and laboratory networks.

Controlling tobacco use. The WHO created and led the Framework Convention on Tobacco Control, adopted in 2003. With the participation of 300 organizations worldwide, the framework has initiated activities to reduce the nearly 5 million deaths attributable to tobacco use every year and has worked with governments to raise their understanding of relevant scientific research. It has also helped raise public awareness of the dangers of tobacco and paved the way, politically, for countries to counter the efforts of tobacco companies.

Tracking diseases. The WHO's Global Alert and Response System systematically tracks disease outbreaks across the world. It investigates over 200 outbreaks each year, with about 5–15 requiring "a major international response."

Developing vaccines and making pharmaceuticals affordable. Public-private partnerships such as the GAVI Alliance have marshaled resources and brought pharmaceutical companies, governments, and donors together to drive the development and distribution of promising new vaccines. Antiretroviral drugs developed by Western pharmaceutical companies and disseminated across the world (including in a major way by companies in India) have slowed the rising tide of AIDS deaths. And pressure from civil society and information campaigns have helped reduce drug prices for global disease threats such as HIV/AIDS.

Global health gaps

No doubt one trigger for greater funding of health has been the UN Millennium Development Goals (MDGs), adopted in 2000. Although not legally binding, they have focused intellectual and financial resources on solving a number of problems that bedevil poor countries. In fact, of the eight goals, three are specific to health, and others indirectly affect health as a stepping stone to a better standard of living.

A recent report of the Global Campaign for the Health MDGs warns that none of these goals is likely to be achieved by the due date of 2015. It says that at the current pace, MDG 4 (reducing child mortality by two-thirds) won't be achieved until 2045; MDG 5 (reducing maternal mortality by three-fourths) won't be fulfilled and maternal mortality rates will worsen in some regions; and regarding MDG 6, although malaria and tuberculosis may well be controlled by 2015, the spread of HIV/AIDS won't have been reversed—HIV infections are still growing fast, outpacing the rising number of people on AIDS treatment. However, the Global Campaign reached its gloomy conclusions about HIV/AIDS before UNAIDS/WHO released its November 2007 "AIDS Epidemic Update," which reports that, finally, and to some extent because of prevention efforts, new infections are decreasing, but are still numerous (estimated at 2.5 million in 2007).

In the midst of a complex and not always coordinated interplay among the various donors and governance organizations, many major health problems remain unaddressed and lack champions. Moreover, a focus on tackling specific diseases may obscure the bigger picture: structural conditions such as poverty and gender inequality also lead to poor health. Unfortunately, increased resources have not led to an across-the-board improvement in global health. For example, research and surveillance programs and financial and technical assistance to address HIV/AIDS, although somewhat (and increasingly) successful in some regions, have not led to sufficiently effective prevention programs or to universal treatment; the disease is thought to have killed 2.1 million people in 2007.

Current health gaps fall into three types:

(1) Core inequalities. *Access to health services and clean water and sanitation:* Approximately 1 billion people lack access to health services, and billions more have inadequate access. Those who do have access are sometimes led to buy useless or even harmful health care—in some circumstances, counterfeit drugs. Clean water and sanitation are not available for much of the world's population, and millions die from waterborne diseases each year as a consequence.

Large disparities in population health status: There continue to be extreme differences in health outcomes between developed and developing countries and within these countries, especially large middle-income countries with huge populations, such as China and India. Agencies responsible for global health governance have been unable to marshal and effectively channel sufficient resources to close these gaps. They have also been unable to stop "brain drain": the movement of trained doctors, nurses, and other health workers from the countries where they are most needed to the developed world, where they can earn higher wages.

Inadequate nutrition: Despite abundant food for most of the population in the developed world, inadequate nutrition—in terms of both caloric intake and specific nutrients—is still widespread in many poor countries.

(2) Gathering and disseminating information. *Global disease surveillance:* Global surveillance is not yet fully equipped to spot and respond to threats, as evidenced by the recent refusal of Indonesia to share viral samples of the H5N1 strain of avian flu with the WHO—a stance aimed at ensuring that a costly and likely scarce vaccine developed from such samples would be available to Indonesians.

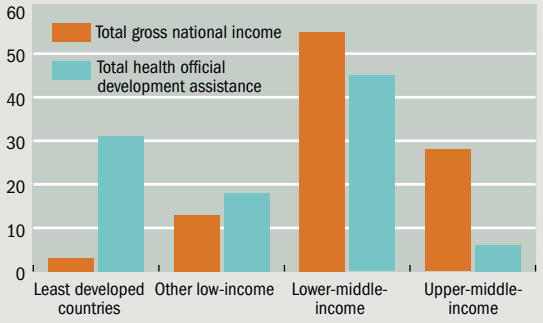
Worldwide dissemination of health information: Some countries, such as Costa Rica, Cuba, and Sri Lanka—and also the Indian state of Kerala—have made particularly effective use of limited resources for improving health. Although these pioneers may have useful lessons to impart, mechanisms for global knowledge sharing are still underdeveloped.

(3) Key governance issues. *Coordination of global agencies:* Governments looking to tackle health problems in their countries face a bewildering array of global agencies from which to elicit support. Health ministries often complain of the large amount of time spent writing proposals and reports for donors whose interests, activities, and processes sometimes overlap, but often differ. Financing mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) are one attempt to pool resources and streamline the process, but

Targeting official aid

The poorest countries received more than 30 percent of bilateral health aid.

(all ODA recipients, income group share, percent)



Sources: World Bank, World Development Indicators, 2007; OECD.

Note: Data are for 2005 and include author's extrapolations in cases where data are available only from earlier years. "Total Health ODA" does not include ODA for health that is not allocated to a specific income group.

similar initiatives are lacking at a health-system (as opposed to disease-specific) level.

Standards for measuring effectiveness of global health agencies: Although the WHO and other UN bodies are accountable to their member states, they often lack detailed and realistic targets for health outcomes or for the intermediate actions they take to promote health—and in any case such global assessments are difficult for a cash-strapped agency to undertake. Similarly, bilateral donors and civil society bodies that work to improve global health are rarely held to account for their successes or failures.

Global intellectual property laws: Patent protection laws vary by country, which has led to conflict between developed and developing countries and between civil society and the pharmaceutical industry over, for example, antiretroviral drug pricing. Countries have not yet found a balance that gives incentives to the private sector to invest in drug development while encouraging adequate attention to the immediate health needs of the poor. Laws and regulations promoting such a balance are unlikely to be agreed upon or effectively enforced without international cooperation.

Picking goalposts . . .

Historically, national governments have taken the lead in safeguarding population health, with very little cross-border cooperation. Yet, as the crossing of national borders has become more common, national governments' control has weakened, and the global effects of the actions of individual countries have intensified. Because health threats are increasingly likely to span multiple countries and regions, national and even bilateral action is no longer sufficient. In many instances, only a pooling of regional or global resources can ensure that population health, in many respects a global public good, is adequately addressed.

Here, it is important to note that one of the downsides of a public good is the potential for market failures in its provision. In the health arena, this sometimes means that if an entity produces a new technology or bit of knowledge whose benefits also accrue to others, it is unlikely to invest as much in that product as it would if it could claim all of the benefits for itself. One example is the paucity of research funding provided by Western governments for work on diseases such as malaria that are major killers in the developing world but not in Western societies (although their long-term impacts on global security and prosperity are unknown). Another example is China's early reluctance to disseminate information about SARS. Immediate action would have benefited health in other countries but potentially harmed China's reputation and its economy, so its pursuit was sluggish.

Which health-related governance issues should top the list for international cooperation? First, ***all countries should have adequate resources to achieve the health-related MDGs***. Bilateral donors are at the heart of international efforts to make sure that disease prevention, treatment, and care in poor countries are properly funded, but such relationships inevitably lead to unequal attention across countries. This matters because neglect of individual countries may have wide-ranging and long-term negative consequences even for the world as a whole. There is also a strong moral case for international aid to spur health improvements in developing countries. In a globalized world, no one can claim ignorance about the appalling conditions in which much of humanity lives.

The good news is that bilateral donors do successfully target their health aid to the poorest countries (see chart). But although many health experts expect foreign aid for health to continue to increase, a recent study (Hecht and Shah, 2007) points out that this is far from certain. Not only might recent increases in development assistance not continue, but donors to health care may become reluctant to continue their expenditures if results are not apparent.

Most central, perhaps, in ensuring adequate funds for health care, is improving the current inefficient use of existing resources. In many countries, basic management and accountability (not to mention resource allocation to the most cost-effective interventions) are largely lacking.

Second, there is a need to ***monitor and assess country-level health issues***. These efforts should include the surveillance of new and existing diseases and the promotion of research into global threats.

Third, there is a need to ***devise means for ensuring adherence to the many rules and standards that are best developed and applied globally***. Global standards (for example, food safety; for pharmaceutical, medical, and other manufactured products; safety levels for air and water; and, with sensitivity to local economic conditions, for labor practices) can help prevent public health crises, including those that cross boundaries. Rules in areas not directly linked to health—such as caps on carbon emissions to slow global warming—may also be vital.

. . . and how to reach the goal line

What steps could be taken to move toward these imperatives? There are multiple ways to strengthen governance arrangements for global health, a few of which are described here.

Clear definition of roles. Because it is accountable to its mostly democratically elected member states, the WHO enjoys considerable legitimacy of public support. It is therefore well placed to take the lead on global health governance, although many believe that its performance needs to be strengthened. The international community should make a concerted effort to come to agreement on whether and how the WHO's mandate should be expanded, whether its authority to promulgate international health regulations should be strengthened, and whether it should be funded at a higher level. The World Health Assembly (the WHO's decision-making body) should perhaps consider new mechanisms that allow for the participation of other global health actors. In addition, the WHO's governance and regional structures should be reformed to give the WHO the teeth it needs.

Increased sharing of experiences. With countries continuing to pursue long-standing health policies and exploring new ones, systematic dissemination of information about the advantages and disadvantages, and the successes and failures, of different approaches is crucial.

Greater coordination. A wide range of donors are working in quite narrow disease-specific fields, but they do not necessarily share a similar ethos, much less similar methods. Developing global indicators that would show the health outcomes associated with donor programs and hold donors accountable for achieving them could help focus resources on the most effective interventions. Also helpful is the International Health Partnership, launched in 2007, which "aims to improve the coordination of support for national health plans and brings together international health organizations and major donor countries, as well as developing countries." Cooperation is to be established in conjunction with the newly created Heads of Health Agencies (the "Health 8"—the WHO, the World Bank, UNICEF, UN Fund for Population Activities, UNAIDS, GAVI Alliance, GFATM, and the Gates Foundation).

Redressing health inequalities. Donors and recipient country governments must strengthen cooperation in defining and advancing developing country health agendas. Much international effort aims to tackle specific diseases, but the underlying causes of health problems must also be addressed. The weakness of health systems is a major factor behind ongoing health deficits in poor countries. Broader structural issues that affect health also require increased attention, including poverty, human rights, gender imbalances, and the powerlessness of poor people to improve their access to quality health care. More proximate determinants of health, such as water and sanitation, pollution, workplace safety, road safety, and violence, are also of obvious and great importance.

Aligning with other arenas. Global health governance arrangements should support and be supported by other international agreements, including those that address labor, trade, and the environment. One test of such agreements is to ask whether they unequivocally help the poor gain access to health care.

Involving other health players. The private sector and civil society can help coordinate local and global efforts. Initiatives such as the GAVI Alliance, the Global Business Coalition on HIV/AIDS, and the World Economic Forum's Global Health Initiative have begun enlisting the support of businesses in promoting global health. Privately run, nonprofit businesses, such as India's Aurolab, have helped make medical technologies accessible to the poor. Still, the potential for cross-sectoral collaboration is far from being realized. The WHO or other international organizations could undertake to monitor, evaluate, and rank corporations on their degree of "health responsibility," much the way that companies are ranked on their "greenness."

Evaluating country governance. Better national governance (for example, reducing corruption, increasing the competence of officials, adopting and/or strengthening democratic practices, and ensuring a central decision-making role for the poorest and least powerful sectors of society) would help countries find the fiscal resources for health. Although important, such reforms will likely still leave the health sector with inadequate resources. A more focused strategy will often be necessary: detailed reexamination of a country's spending with the explicit aim of redirecting a greater share of funds toward health.

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As we move forward, we should think about governance not only as the institutions discussed here, the relations between them, and the rules and standards they follow. We should also think about the need for civil society to engage in a discussion about what we want good governance to achieve and about what citizens of an increasingly globalized world owe to, and can expect from, each other. In this context, information sharing is not just the exchange of technical information but also an interchange about values, expectations, and accountability.

None of the above reforms will be possible without buy-in from both rich and poor countries. Tackling ill health in poor countries would be the right thing to do even if it did not have broader impacts on economies, social stability, and international security. In a globalized world, however, the potential consequences for societies across the world, rich and poor, make a strong global health governance system imperative. ■

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