Overseeing Global Health

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New actors, with new priorities, are crowding a stage the World Health Organization once had to itself

THE recent outbreak in west Africa of the highly infectious and often fatal Ebola virus highlights the need for global cooperation in health. The current Ebola crisis—along with the outbreak of Middle East respiratory syndrome (MERS) and the resurgence of polio in the Middle East and Africa—is simply the latest example of governments' inability to control the spread of infectious diseases when they act in isolation: global rules negotiated among governments are crucial to protecting the health of citizens.

The Ebola outbreak is precisely the type of crisis world governments had in mind when they founded the World Health Organization (WHO) in 1948 and placed it at the center of *global health governance.*

WHO Ebola awareness campaign in the village of Kolobengu, Guinea.

The fight against Ebola, which the WHO declared an international emergency in August 2014, requires careful reporting of the spread of the disease to allow authorities to track it, concerted international efforts to contain it, and resources to treat those infected. These needs pertain to global health governance—the rules and related formal and informal institutions, norms, and processes that govern or directly influence global health policy.

The essential functions of health governance, which are generally within the purview of the WHO and its governing board, include convening key stakeholders, defining shared values, establishing standards and regulatory frameworks, setting priorities, mobilizing and aligning resources, and promoting research.

Global governance requires governments to forgo aspects of their sovereignty by delegating certain prerogatives and authority to an international agency such as the WHO. Rules such as the International Health Regulations, which direct countries' response to international health risks, are a clear example of such delegation of authority.

But in recent years new organizations have begun to crowd the global health stage. Specific concerns—about, say, HIV/AIDS or maternal mortality—have brought more money into the global health system. But those additional funds are often channeled through the new institutions. Some work within the WHO, some outside it, and others do both. In contrast to the wide, integrated mandate of the WHO, the focus of most of these new organizations is *vertical*, concentrated on narrow goals, such as a particular disease or condition.

Protecting the health of citizens across the world requires long-term investment in the WHO and its broad mandate. But donors with focused, short-term objectives are driving much WHO activity, and new partnerships aimed at specific diseases and issues are gaining prominence. Yet there is growing awareness of the need to strengthen health systems—the people, organizations, and resources at the center of health care delivery—to complement disease-specific efforts. Moreover, the recent efforts of Latin American, Asian, and African nations to play a larger role in global institutions is affecting global health governance.

A growing crowd

The original purpose of the World Health Organization was, among other things, to ensure that governments would collaborate on health matters with a long-term perspective. To that end it was given more authority and resources than its predecessor organization under the League of Nations. Virtually every government in the world is a member of the one-country, one-vote World Health Assembly, which governs the WHO.

As a result of this changing environment, the WHO faces both financing and governance difficulties.

However, the WHO is no longer the only global health institution and today faces stiff competition in some areas from new actors, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund); GAVI, The Vaccine Alliance; and the Bill & Melinda Gates Foundation, the world's largest private foundation whose core focus is global health.

Over the past half century, the World Bank too has become increasingly influential in global health care, with considerable resources, access to senior decision makers in ministries of finance, and in-house technical expertise. The bank has lent billions of dollars to governments to help them improve their health services.

As a result of this changing environment, the WHO faces both financing and governance difficulties. Although total resources have not diminished, they have not grown much in recent years either. The organization's 2012–13 budget was $3.95 billion; its 2014–15 budget is $3.97 billion (WHO, 2013). But the real challenge is the constraints on the way much of that money can be spent. About 80 percent of the WHO budget is "voluntary" funding from donors with specific mandates and cannot usually be spent for general purposes. A shortage of unrestricted funds was one of the factors that hindered the WHO response to the recent Ebola outbreak (see box). What has been criticized as a slow initial reaction to the epidemic has sparked some calls for creation of a new global fund to respond to infectious disease outbreaks.

Voluntary funding—which comes from government donors such as the United States and Japan and from private sources—can be earmarked for specific diseases or initiatives, such as the Stop TB Partnership, or specific regions, such as the Americas. Over the past 12 years, voluntary contributions have increased 183 percent, while assessed core contributions from member countries have increased only 13 percent (Clift, 2014). During 2012–13, the WHO had discretion over the use of only 7.6 percent of voluntary funds. Moreover, administrative costs for management of the more than 200 voluntary contributors approached $250 million, more than 5 percent of its budget. Still, without voluntary funding it is likely that the total WHO budget would be much smaller.

Governments overall remain the WHO's primary source of funds (assessed and voluntary), but nongovernmental organizations (NGOs) are increasingly influential. The $300 million the Gates Foundation donated in 2013, for example, made it the WHO's single largest contributor. In some cases NGOs help implement WHO programs—The Stop TB Partnership, for example, which seeks to eradicate tuberculosis. NGOs are seeking power and voice in global health governance through board membership and voting rights in international institutions, but they have only observer status at the WHO—governments direct policy. The challenge is for the WHO to engage meaningfully with this wider range of stakeholders while maintaining its status as an impartial intergovernmental body that benefits all its members equally.

The WHO has had to deal with some discontent on that issue. For example, in 2007, the Indonesian health minister refused to supply H5N1 virus samples to the WHO for analysis and vaccine preparation, despite global concern about an outbreak of avian flu (Gostin, 2014). The minister argued that vaccines and drugs derived from its viral samples were unlikely to become available to developing countries and invoked the principle of viral sovereignty to withhold samples until a more equitable system for access to vaccines in a pandemic was established. After tense negotiations, member states agreed in 2011 to the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits. The agreement seeks to balance

Response to Ebola

The World Health Organization (WHO) has been criticized for a slow and weak initial response to containing the Ebola virus outbreak in west Africa. The agency cites a lack of in-house technical expertise and staff. Because so much of its budget is decided by donors who earmark funds for their short-term priorities, the WHO's core strength in emergency and epidemic and pandemic response has atrophied over the past decade. Its outbreak and crisis budget was cut in half, from $469 million in 2012–13 to $241 million in 2014–15 (WHO, 2013), and its epidemic and pandemic response department was dissolved and its duties split among other departments (*New York Times*, 2014). In September 2014, donors such as the Bill & Melinda Gates Foundation pledged funds to the WHO, but there is a need for long-term sustainable financing for the organization that is at the center of global health governance.

improved and strengthened sharing of influenza viruses with efforts to increase developing countries' access to vaccines and other pandemic-related supplies.

As the Indonesian incident demonstrates, international institutions must balance buy-in by the powerful (who often have a special degree of influence) against the need to assure all members, including the least powerful, that their interests are best served by belonging to and participating in the organization. Countries must trust an international agency to report infectious threats and use the health information it gathers for the general benefit, without stigmatizing or denigrating the countries where threats arise. The revised 2005 International Health Regulations require its nearly 200 signatory countries to report to the WHO certain public health events of international concern (such as Ebola outbreaks) and establish procedures that the WHO and its members must follow to uphold global public health security. The regulations seek to balance sovereign rights with a shared commitment to preventing the international spread of disease.

The flip side of the emergence of new actors on a stage once occupied by the WHO alone is that countries seeking the best way to achieve their health goals have more options. For example, countries can apply to the Global Fund or the Gates Foundation for money to fight TB and bypass the WHO, forcing the long-time leading player to examine its role and arguably operate more strategically. The WHO was never meant to undertake every global health function, partly because when it was founded there were already regional public health agencies (such as the Pan American Health Organization). Its main strength is as a forum that brings together various stakeholders but permits only member governments to negotiate global health rules and determine the support countries receive from the WHO to disseminate and implement those rules.

Partnership

The still relatively new story in global health cooperation is the emergence of public-private partnerships such as the Global Fund and GAVI. The governance structures of these vertical funds differ in important ways from those of the WHO and the World Bank (Sridhar, 2012).

Vertical funds have *narrowly defined goals*, unlike the broad mandates of the WHO ("the attainment by all people of the highest possible level of health") and the World Bank ("to alleviate poverty and improve quality of life"). The Global Fund's mandate is to attract and disburse resources to prevent and treat HIV/AIDS, tuberculosis, and malaria; GAVI's is to save children's lives and protect health more broadly by increasing access to childhood immunizations in poor countries.

Critics claim that these new global health resources go to pet concerns of donors and often would be better deployed by a multilateral body like the WHO. But it seems unlikely that the resources, which represent a net increase in global health funding, would otherwise be available to serve the broader WHO mandate. The Gates Foundation provided the initial impetus for GAVI with a $750 million pledge, and the Group of Eight governments (Canada, France, Germany, Italy, Japan, Russia, United Kingdom, United States) specifically bypassed the United Nations in launching the Global Fund in 2002.

Vertical funds *empower diverse stakeholders*, unlike the WHO, which invests only governments with the authority to coordinate policies and, at times, collective actions. The Global Fund's board includes voting members from civil society, the private sector, and the Gates Foundation—as well as representatives from developing and donor countries. It also includes as nonvoting members such partners as the WHO and the World Bank. GAVI also has a multistakeholder board, which includes as permanent voting members the Gates Foundation, UNICEF, the WHO, the World Bank, and 18 rotating members from developing and donor country governments, vaccine makers, and civil society. Enfranchising nongovernment actors has engendered greater legitimacy for GAVI and the Global Fund among those groups (Wallace Brown, 2010).

These initiatives are *funded entirely by voluntary contributions,* whereas the WHO and the World Bank financial models are based on assessed contributions, despite the growing number of voluntary donations to the WHO. The Global Fund receives voluntary contributions from governments, individuals, businesses, and private foundations. GAVI relies on donor contributions to support the development and manufacture of vaccines. Governments are the more significant source of funding, but solely through voluntary mechanisms.

GAVI and the Global Fund do *not work directly in recipient countries*, unlike the WHO and the World Bank, which work through government agencies and have offices and personnel in recipient countries.

The Global Fund relies on country coordinating mechanisms to develop and submit grant proposals and choose organizations to implement them. These mechanisms usually include representatives from the applicant country's government, local and international NGOs, interested donors and private sector representatives, and people who have the targeted disease. GAVI funds national governments, which use the resources to increase vaccine coverage.

The Global Fund and GAVI *derive legitimacy from their effectiveness in improving specifically defined health outputs and outcomes,* unlike the WHO and World Bank, which stand on their status as inclusive, participatory intergovernmental bodies.

Moving toward health systems

Vertical funds continue to proliferate, and targeted contributions are still the bulk of WHO donor funding. But advanced and developing countries are increasingly focusing on the need for robust primary care and strong hospital systems—a horizontal approach. Ebola's spread across west Africa shows the need for stronger health systems, not only to provide maternal and child health care and confront noncommunicable diseases such as cancer and heart ailments, but also to detect and treat infectious diseases. Ethiopia, for example, established programs to build comprehensive health systems funded by increased domestic investment and donor support.

Vertical funds, though, have stayed out of efforts to strengthen health systems or ensure health care for all members of society (universal health coverage). For the most part these donors believe domestic resources are growing fast enough to enable recipient countries to strengthen their health systems and provide universal health coverage. They also worry that governments would use new funds as an excuse to reduce their health investment. National programs must be country led, these donors believe, and designed domestically because of differences among health systems (for instance, whether a country already has a domestic private care delivery system), domestic insurance markets, and government approaches to prevention of noncommunicable diseases. Many donors are also wary of further fragmenting global health governance.

But the rapid spread of the Ebola virus in West Africa highlighted the difficulties that poorly funded health systems had in identifying, then containing the disease. The United States has pledged more than $250 million and the United Kingdom more than $200 million to support the response to the outbreak, some which is destined to improving health systems. Whether the Ebola crisis will elicit more sustained contributions from vertical funders to improve health systems is unclear.

Rise of emerging markets

In recent years, emerging market economies have demanded a greater role in multilateral institutions—from the IMF to the United Nations. That new assertiveness has spilled over into global health, where the major emerging market economies are playing a role that reflects both their domestic needs and their constraints. When the most economically advanced emerging market economies—Brazil, Russia, India and China (BRICs)—have engaged in the area of global health, it has generally been in issue-specific areas, such as access to essential medicines or technological cooperation, such as in TB treatment.

Regional concerns also appear to drive engagement in international cooperation and have given rise to regional health-related bodies in Africa, Asia, and Latin America. Since its launch in 2002, for example, the African Union has involved member states' health ministers in such regional health issues as infectious diseases, health financing, food security, and nutrition. Brazil, India, and South Africa have agreed to work together to coordinate international outreach on health and medicine. Whether these developments will strengthen the WHO—with regional bodies acting largely as WHO adjuncts—or chip away at its authority is hard to predict.

Notably, global health takes a backseat to other international issues, such as financial policies and national security, in China, India, and Russia. Brazil has embraced health issues as central to its foreign policy agenda, but—as measured by its participation in the Global Fund at least—has not stepped up financially.

The Global Fund directors continually call on emerging market economies to shoulder some of the financial burden of fighting HIV/AIDS, TB, and malaria, but Brazil, which has received $45 million in grants, has contributed only $200,000. The story is similar with other BRICs. India has received $1.1 billion and donated only $10 million; China has received $2 billion but donated only $16 million. Russia's record is better: $354 million received and $254 million donated.

During the global financial crisis, hard-hit advanced economies scaled back or even eliminated their commitments to the Global Fund. The BRICs weathered the crisis better than many advanced economies. Their failure to step up commitments to the Global Fund (or to GAVI) since the crisis raises questions about their long-term commitment to global health leadership.

How long should the BRICs, the four largest emerging market economies, continue to receive development assistance for health? India is the largest recipient of external health funding, China the 10th largest, and Brazil the 15th largest. At issue is whether aid should continue to subsidize countries that can arguably afford to provide at least basic health care and that have an increasing economic interest in halting infectious diseases, whether old scourges like TB or newer concerns like the avian flu virus.

But despite their middle-income status, Brazil, China, and India remain relatively poor in per capita terms and must focus on economic growth. Because they also face massive health problems, donors still believe that continued health assistance is justified. But multilateral institutions and bilateral donors must continually examine whether middle-income countries should continue to receive aid that might better be used in poorer countries.

A key lesson from the Ebola crisis is the need for a strong, organized global response and an authoritative, well-funded WHO to lead it. Whether the outbreak impels member states and other powerful stakeholders to strengthen the WHO's resources and authority or to set up another institution to fight disease outbreaks will be the critical global governance issue of the next few years. ■

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