

IMPROVING GLOBAL HEALTH GOVERNANCE

Technical briefing paper for the Child Health Now campaign





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Front cover image: Women wait with their children outside the World Vision-funded nutrition centre at Tallague Clinic, Niger.

Photograph © Reuben Schug / World Vision

Executive Summary

In the last two decades, efforts to improve health in the developing world have enjoyed increasing international political support, attention and resources, contributing to significant reductions in child and maternal mortality.

The growing number of actors supporting global health efforts has not, however, been effectively coordinated, resulting in inefficiencies, confusion and weak accountability to those most in need of assistance. World Vision believes that the cost of the current complexity can be counted in the missed opportunity to make further inroads into reducing the more than 8 million preventable child deaths that continue to occur each year.

This paper seeks to identify the most pressing challenges in relation to global health governance. Levels of both domestic and international resourcing for health are insufficient to meet the identified needs; international assistance is unpredictable and often neither allocated in line with national priorities nor distributed using national systems. Finally, aid has not been directed according to the greatest burden of mortality, particularly with regard to fragile states.

In January 2011, the Director-General of the World Health Organization (WHO), Margaret Chan, put forward a proposition for future financing of the WHO which included a proposal for new mechanisms for global health governance, such as a new global health governance forum. Through this paper, World Vision aims to contribute to the conversation about global health governance. Our particular interest is in ensuring the meaningful inclusion of civil society actors and the voices of the poorest families and communities in deliberations about the design of global health systems. We call for increasing international and domestic resources to be allocated to health, aligned with national plans and directed to reaching the most vulnerable, particularly women and children.

The design of global health governance requires choices about normative frameworks, institutions, membership, leadership, resourcing and enforcement mechanisms. World Vision believes that an improved global health governance system should be organised around the right to health; and that membership should be inclusive of governments, multilateral institutions, foundations, civil society and the private sector, with the WHO exercising a coordination and leadership role. Resourcing should be allocated on the basis of a recognised mutual responsibility to improve health outcomes, giving priority to reducing the continuing high levels of preventable maternal and child mortality. Given that there is no binding enforcement mechanism, compliance with new norms will require creative systems of positive incentives and mutual accountability. Finally, recognising recent efforts towards greater harmonisation and alignment by a number of global health actors, we call for the proposed new mechanism to ensure that institutions provide sufficient and reliable resources to support the implementation of agreed national plans.

The design of global health governance requires choices about normative frameworks, institutions, membership, leadership, resourcing and enforcement mechanisms.



World Vision believes that an improved global health governance system should be organised around the right to health.

URGENT RECOMMENDATIONS

- World Vision supports Director-General Chan's proposal to create a regular multi-stakeholder forum but suggests that such a forum be set up as a smaller, more robust global health governance council,¹ composed of a limited number of elected representatives from wider constituencies.
- The global health governance council should
 - feed into existing consultation and decision-making processes of the WHO
 - be based on the progressive realisation of the right to health
 - be chaired by the WHO
 - aim to expedite the development of a non-binding global health charter that emphasises shared responsibility, mutual accountability and alignment of international assistance with developing countries' priorities. This charter would help to shape agreement on global health and improve cooperation and solidarity between stakeholders
 - consider the results of the final report of the Organisation for Economic Cooperation and Development (OECD) Task Team on Health as a Tracer Sector for opportunities at country level to promote the effectiveness of international and domestic resources through mechanisms such as the International Health Partnership and related initiatives (IHP+).²
- World Vision calls on the WHO to coordinate current efforts to address global health governance with the work of the Commission on Information and Accountability for Women's and Children's Health and the related accountability framework that will be presented to the 64th World Health Assembly (WHA).

LONGER-TERM RECOMMENDATIONS

- The global health governance council should
 - investigate the positive and negative impacts of working towards a more binding global health convention that clarifies global health priorities, as well as national and international responsibilities, in line with the right to health
 - investigate the optimal composition of a global health 'regime' and its relationship with global health organisations to implement and monitor adherence to the global health charter (and convention, if agreed).

Foreword

All children, no matter where they are born or their family's circumstances, deserve an equal opportunity to enjoy life in all its fullness. It's unacceptable that close to 8 million children below the age of five are allowed to die each year from preventable causes.

In nearly 100 countries, World Vision is working with communities and other partners to turn this situation around. We're at the midpoint of our Child Health Now campaign to reduce that annual toll of deaths, and offer a new chance at life for 6 million children a year by 2015. As part of the Child Health Now campaign, World Vision is conducting new research and testing innovative solutions to help address the underlying causes of preventable child deaths. We are investing heavily in child health in our work with communities and advocating with them for better local health funding and systems.

Improving Global Health Governance is based on our experiences with those communities. We have seen many well-intentioned initiatives and interventions, driven by top-down decisions rather than by the needs on the ground. A more coherent approach to setting priorities would truly benefit children. That does not mean a one-size-fits-all solution, just a more consistent and transparent international response generated by people's real needs. Changes are required in global and national health architecture to make health services more coordinated and effective.

This paper contributes to the debate about how to improve global health governance, and thus health outcomes. It addresses suggestions by the World Health Organization (WHO) and sets out principles to guide the formation of its proposed new global health forum.

We support the role of the WHO to act as the directing and coordinating authority on international health work,³ and we call on member states to increase their support for it, to ensure it is able to perform its many roles more effectively.

The rights of children, as laid out in the UN Convention on the Rights of the Child, are fundamental to global progress and improved health outcomes. The Committee on the Rights of the Child recently decided to develop a general comment on Article 24 of the Convention, which concerns the right to child health. This is welcome, as it will lead to better health for women and children and will make it more likely that the health-related Millennium Development Goals (MDGs) will be achieved.

All the recommendations in the following pages reflect the centrality of children's well-being to our mission. Along with their families and communities, we dream about a better future for children. These dreams are the foundation of the changes we seek in child health governance.



Kevin J Jenkins

President and Chief Executive Officer
World Vision International

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Introduction

In the last decade, efforts to improve health in the developing world have enjoyed increasing international political support, attention and resources. More than 100 different organisations now focus on global health – including 40 bilateral donors, 26 UN agencies, 20 global and regional funds, multilateral institutions, private foundations, philanthropists and more than 90 global health alliances.⁴ Although a positive development overall, this multitude of global health stakeholders creates increasing complexity, and at times confusion, which can hamper the efficient spending of finite resources. How can we improve global health governance, and will this actually save lives?

Governance can be understood as the ‘actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals’.⁵ Global health is ‘an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide’.⁶ **Global health governance**, then, is about the actions and means adopted by ‘global society’ to improve health and to achieve equity in health worldwide.

However, global society has no global government, or global health ministry, to coordinate actions and to make the necessary means available. Global governance relies on voluntary cooperation among sovereign countries. The WHO has been given the mandate ‘to act as the directing and coordinating authority on international health work’⁷ and can be seen as ‘the ministry of health of the world’, as far as nations’ sovereignty allows, but it has not been given the requisite powers to fulfil that role.

Coordination among sovereign countries, even when they have a common objective, is not self-evident. Every country, whether it acts predominantly as an international assistance contributor or as an implementer of internationally co-financed efforts, wants to preserve its autonomy. Nonetheless, we live in a world that is increasingly affected by global challenges, in health and far beyond health, and important benefits can be expected from increased and improved coordination, as will be discussed below.

In this paper we review the weaknesses and problems of current health governance arrangements and consider some of the proposed solutions. The paper is informed by World Vision’s experience in countries across the globe, academic perspectives and discussions with representatives of many of the main actors in global health governance.⁸

World Vision hopes that this paper helps to further debate on global health governance. This debate should ensure that any new mechanisms and processes uphold the right to health as their guiding principle and ensure that the voices of the poor, including women and children, are heard.

Global health governance is about the actions and means adopted by ‘global society’ to improve health and to achieve equity in health worldwide.

Aid needs to be provided and spent more effectively, and programmed in line with need.

The Present State of Global Health Governance

Between January 2004 and November 2005, the WHO and the World Bank co-chaired the High-Level Forum on the Health Millennium Development Goals. As a result the WHO developed an outcome paper which highlighted six areas of consensus. These consensus statements can be used to summarise an agenda for the reform of global health governance which proposes actions and means adopted by global society, to improve health and to achieve equity in health worldwide.⁹

So what has been achieved since then? The question is not easy to answer, as the time lags between the collection and publication of reliable empirical data are often several years. However, by reviewing data from 2000 to 2007 and examining new initiatives, we can discern trends.

FOREIGN AID

Promised increases in aid... are welcome. However, aid needs to be provided and spent more effectively, and programmed in line with need. In particular, aid must be more predictable.¹⁰

Aid for health did increase between 2000 and 2007, as documented in Table I. In low-income countries, on average, external resources increased from 10.2 per cent of total health expenditure to 17.5 per cent. Calculated as per capita annual expenditure, external resources increased from US\$1.40 to \$4.70. Compared with average government per capita annual expenditure in high-income countries (\$2,699) it still remains very low, but there has been progress.

Table I. Global health funding levels

Income group	External resources for health as % of total expenditure on health		Per capita expenditures on health from external sources at average exchange rate (US\$)		External resources for health as % of total expenditure on GDP		Domestic government expenditure on health as % of GDP	
	2000	2007	2000	2007	2000	2007	2000	2007
Low income	10.2	17.5	1.4	4.7	0.48	0.93	1.7	1.8
Lower middle income	1.1	1.0	0.4	0.8	0.05	0.04	1.8	2.0
Upper middle income	0.6	0.2	1.3	1.0	0.04	0.01	4.1	4.4
High income	0	0	0	0	0	0	8.6	9.6

Source: WHO Statistical Information Services (WHOSIS), World Health Statistics 2010.¹¹

Has international assistance become more aligned with national needs?

The findings of Jeremy Shiffman and colleagues, illustrated by Figure 1, seem to suggest otherwise.¹² It appears that the prioritisation of HIV and AIDS relative to other priorities continued after 2005. Whether this is in line with low-income countries' needs is questionable.

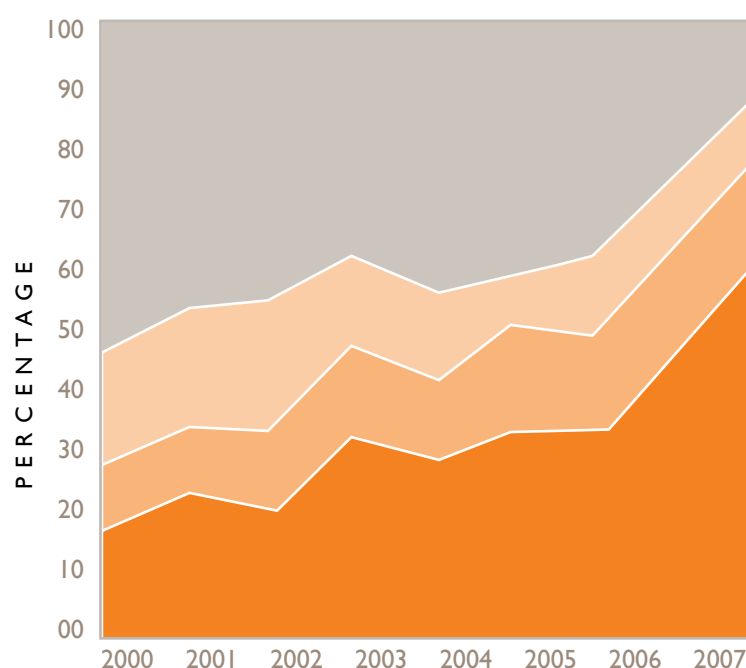
Figure 1 represents the allocation of international assistance for certain priorities as percentages of all international assistance for health, and can be interpreted in two fundamentally different ways:

- 'Too much' international assistance is being allocated to HIV and AIDS.
- Not enough international assistance is being allocated to health systems strengthening and efforts towards the attainment of MDGs 4 and 5, on child and maternal health.

The WHO Regional Director for Africa,¹³ referring to the MDG Africa Steering Group,¹⁴ estimates that Africa needs \$12 billion in international assistance per year to fight HIV and AIDS but can count on only \$6 billion, while Africa needs \$10 billion in international assistance per year for child survival, maternal health and health systems strengthening but can count on only \$5 billion. Both segments are at 50 per cent of needs, so 'robbing Peter to pay Paul' is not a solution here. Both need to be funded.

There is a serious risk that the global community may sacrifice some lives for others by increasing international assistance for health systems strengthening and attainment of MDGs 4 and 5 through concurrent reductions in international assistance for HIV and AIDS. It is imperative that the international community advocates for new funds to address the underinvestment in health systems strengthening and efforts towards the attainment of MDGs 4 and 5 while tracking the overall resources being invested in both maternal and child health and HIV and AIDS.

Figure 1. Global allocation of aid



Source: Shiffman, et al, 'Has Aid for AIDS Raised All Health Funding Boats?' (2009) ¹⁵

Not enough international assistance is being allocated to health systems strengthening.

Has aid become more or sufficiently predictable?

The critical question in relation to predictability is whether aid is reliable – aid could be predictably unreliable, which would not help. Why is unreliability a problem, and how reliable should international assistance be, to be effective? These questions are not easy to answer; precise answers vary from one developing country to the next.

Lane and Glassman found that ‘aid flows to the health sector are volatile in terms of observed outcomes and uncertain in terms of making and delivering future commitments’, and they argue that ‘[t]he aid is therefore poorly suited to fund recurrent costs associated with achieving the Health Millennium Development Goals, particularly funding of Primary Health Care’.¹⁶ Foster makes a similar observation and explains that ‘[g]overnments are therefore understandably reluctant to take the risk of relying on increased aid to finance the necessary scaling up of public expenditure.’¹⁷

For example, if a country has a health budget from national resources of \$200 million and \$100 million in international assistance, and can reasonably hope to increase national resources to \$300 million in 2020 because of economic and government revenue growth, then the international assistance, or at least a part thereof, should be reliable until 2020. Gradually, national resources would replace international assistance, without creating a problem. However, if the international assistance is guaranteed until 2015 only, there may be a problem in 2016: by then, national resources for health would probably have reached only \$250 million, and this country may have to reduce its overall health budget from \$300 million to \$250 million. That is a risk that governments may be reluctant to take when it involves long-term spending such as staffing and maintenance of equipment and systems.

AID EFFECTIVENESS

Global Health Partnerships [GHPs] represent a particular challenge in applying the Paris Principles to the health sector. GHPs must therefore be fully engaged in the aid effectiveness dialogue.¹⁸

Global health partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund or GFATM) or The Global Alliance for Vaccines and Immunisation (GAVI) have the advantage of offering secure funding for priority health outcomes. The restricted mandate of these organisations can create particular challenges when it comes to compliance with the ‘aid effectiveness’ principles. The Paris Declaration on Aid Effectiveness of 2005 and the Accra Agenda for Action of 2008 are based on the assumption that alignment of international assistance with developing countries’ plans leads to increased effectiveness and efficiency.¹⁹ The particular challenge for GHPs, then, is that developing countries’ health plans must consider the entire range of health challenges, while GHPs can finance only segments of such plans, inevitably leading to fragmentation of financing streams.

Since the inception of GHPs, there has been an ongoing dialogue on how to improve harmonisation and alignment of GHPs with national plans and priorities. In 2005, at the High-Level Forum on Global Health Partnerships, guiding principles were developed to promote integration with national health systems.²⁰ As with many self-monitored processes, however, these principles were not accompanied by an effective enforcement mechanism. Recently, both the Global Fund and GAVI have been working together to develop a health systems funding platform for the health systems portion of their application process.


The IHP+ aims to align international assistance with national health plans. It encourages countries to develop comprehensive and long-term health plans, which can then be used by all partners, including GHPs, as the basis for their funding. The overall alignment with countries' plans would thus result from all donors taking responsibility for a part of the plan (not necessarily from all donors supporting the entire plan). An acknowledged weakness of the IHP+, at present, is that it lacks norms about priorities and national and international responsibility. The first wave of comprehensive health plans remains underfunded by national and international donors, leaving both donors and recipients disappointed.²¹ Ethiopia, Mali and Mozambique have seen the most improvements in Development Partners' actions to meet their IHP+ targets. Burundi, Djibouti, the Democratic Republic of the Congo (DRC), Niger and Nigeria have benefited less. However, these results might be expected given the length of time since each country joined the IHP+ (Djibouti signed up to the IHP+ Global Compact only in July 2009, Niger and the DRC in May 2009) and the relative strength of these countries' systems and processes.²²

Both the Global Fund and GAVI signed up to the IHP+.²³ The IHP+ developed a Joint Assessment of National Health Strategies and Plans (JANS) tool,²⁴ which can be used by countries – in an adapted form – to submit proposals to the Global Fund and GAVI.²⁵ As mentioned above, the World Bank, the Global Fund and GAVI created the Health Systems Funding Platform.²⁶ Here again the stated objective is that countries can use a single plan to submit proposals to both the Global Fund and GAVI.

While these new initiatives are too young to be evaluated on their performance, one cannot deny that serious attempts are being made to improve GHPs' compliance with the principles of 'aid effectiveness'. World Vision believes that there are advantages in both GHPs and newer initiatives such as the IHP+. The challenge is to further the incipient efforts towards effective integration and to establish a global health governance architecture that provides GHPs with incentives to align with developing countries' plans and health systems strengthening.



Global Health Partnerships represent a particular challenge in applying the Paris Principles to the health sector.



There is a need for increased investment in the systems and staff needed to deliver health outcomes, including information systems.

HEALTH SYSTEM STRENGTHENING

There is a need for increased investment in the systems and staff needed to deliver health outcomes, including information systems.²⁷

Over the last decade increasing attention has been paid to the need to support and strengthen national health systems. This has been expressed in G8 pledges, WHO resolutions, regional resolutions, and national plans and strategies.²⁸ Donors have begun to invest in longer-term and more predictable aid through mechanisms such as sector-wide pooled funding, budget support and joint agreements, and assessments made through country compacts among all donors in the case of the IHP+.

The *World Health Reports* (WHRs) of 2005, 2006, 2008 and 2010 explore the gaps that exist in ensuring that women and children have access to essential health care and services. They focus on the importance of strengthening health systems and ensuring that services are delivered as close to communities as possible (including them in the design, planning and evaluation of the systems). The 2005 WHR *Make Every Mother and Child Count*²⁹ led to 189 member states signing WHA resolution 58.31,³⁰ which highlights the investments required to ensure that health systems are strengthened to deliver evidence-based interventions to those who need it. In 2006 the WHR *Working Together for Health*³¹ highlighted the fact that more than 50 countries were trying to deliver health services without having a critical level of health workers and that 4 million more health workers were required to ensure the achievement of the MDGs.

In the maternal and child health area alone there is clear evidence that approximately 6 million lives can be saved each year³² if proven and cost-effective strategies can be brought to all people. The essential requirement to achieve this is an adequately resourced community- and district-level health system in each country.

One recent development in the area of maternal and child health is the UN Secretary-General's Global Strategy for Women's and Children's Health, launched in September 2010, which aims to save 16 million lives by 2015 through an approach that has been summarised as 'more money for health, more health for the money'.³³ The WHO has been tasked by the UN Secretary-General to lead the process of developing an accountability framework for the implementation of the Global Strategy and is currently coordinating the Commission on Information and Accountability for Women's and Children's Health. World Vision believes that the problems of global health governance, and therefore related solutions, lie beyond the scope of this Commission but that it is important for the WHO to ensure that the two processes are coordinated and mutually reinforcing.

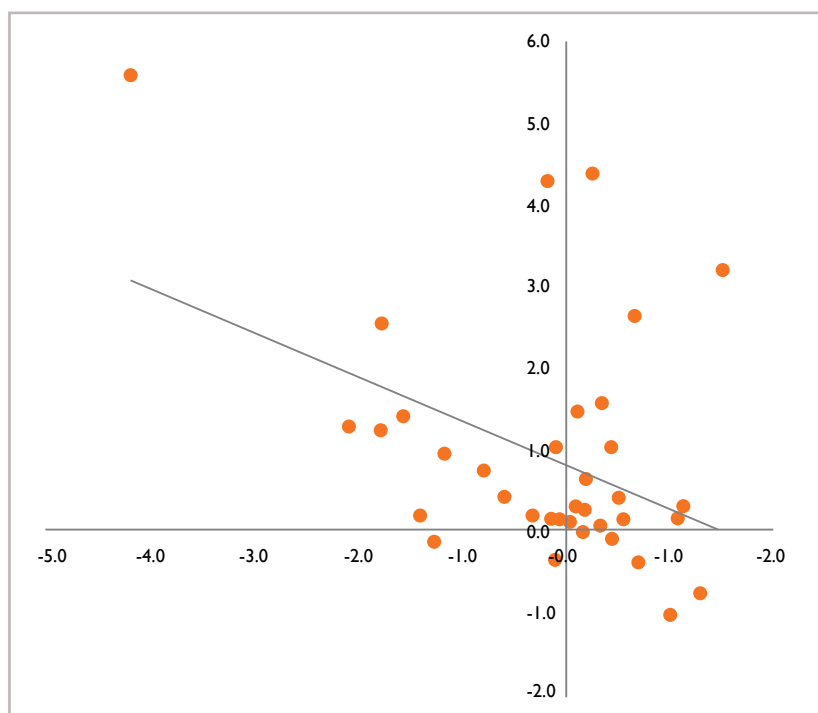
DOMESTIC PRIORITISATION

Ministries of finance need to be convinced of the importance of health if domestic resource allocation is to increase.³⁴

Looking at Table 1 above again, one could (too easily) conclude that ministries of finance of low-income countries have not been convinced of the importance of health. While some low-income countries have increased their domestic health funding significantly,³⁵ on average, domestic government health expenditure (calculated as total health expenditure minus external resources, minus out-of-pocket private health expenditure) in low-income countries increased from 1.7 per cent of gross domestic product (GDP) in 2000 to only 1.8 per cent of GDP in 2008, while external resources increased from 0.5 per cent of GDP to 0.9 per cent of GDP. This suggests that the governments of developing countries on average did not rise to the occasion; they did not match increasing international assistance for health with corresponding increases in national resources for health.

Overall domestic government health expenditure did increase, which seems to contradict the findings by Farag and colleagues³⁶ and Lu and colleagues,³⁷ according to which low-income countries reduce domestic government health expenditure in reaction to increasing external resources. But when we examine how individual low-income countries reacted to increases in external resources, we do find a negative correlation, as Figure 2 illustrates.

Figure 2. Changes in external resources and changes in domestic government health expenditure, 2000–2007



Source: WHOSIS, World Health Statistics 2010³⁸

In the maternal and child health area alone there is clear evidence that approximately 6 million lives can be saved each year if proven and cost-effective strategies can be brought to all.



The WHA is the only place where Ministers of Health from 193 countries come to discuss and decide upon global health policies and standards.

Almost all low-income countries benefited from increasing external resources for health; the handful that did not are represented by dots below the horizontal axis. Some of them nonetheless increased domestic government health expenditure (dots on the right of the vertical axis), while others decreased (dots on the left of the vertical axis). The trend line, however, indicates that the more external resources increased, the less domestic government expenditure did.

It would, however, be unfair to blame only the governments of developing countries for this. As discussed above, the unreliability of international assistance in the long term can explain why some developing countries did not and do not match increasing international assistance for health with increasing domestic government expenditure on health. Stuckler and colleagues add that international assistance provided under a borrowing agreement with the International Monetary Fund (IMF) seems to have a far stronger inhibiting effect on domestic government health expenditure than that from other donors.³⁹

FRAGILE STATES

There are a number of ‘donor orphans’ which require higher levels of aid for health – these are often fragile states, where provision of development assistance is particularly challenging.⁴⁰

The problem with ‘donor orphans’ (low-income countries with weak bilateral support) is that, in a global society without a global government, donor countries remain sovereign and direct their aid to governments they prefer because of national, cultural, security, economic or other interests: these interests are generally unrelated to health needs.

There are some solutions to this problem. The Global Fund, for example, established a Technical Review Panel, composed of independent experts. Once a proposal is approved by the Technical Review Panel, a donor country government cannot then decide to deny funding to that proposal on the grounds that it would prefer its international assistance to be directed towards the proposal of another developing country.⁴¹ In other words, so-called ‘donor orphans’ are less likely to be excluded by GHPs or organisations that established independent technical review mechanisms. However, these organisations can cover only a limited segment of resources required, because of their restricted mandates.

Greater attention is needed to the circumstances of fragile states where governments are unwilling or unable to address the health needs of their people.⁴²

The problem with countries able but unwilling to address the health needs of their people, or marginalised groups within their society (like women and children in the hardest-to-reach or marginalised populations), is even more difficult to solve. First, there are no internationally agreed criteria on appropriate efforts, nor on how hard a country should try to make appropriate efforts, and therefore it is difficult to judge whether a government is ‘able but unwilling’ or ‘willing but unable’. Second, international assistance can never be a substitute for ‘able but unwilling’ governments.

Challenges for Global Health Governance

Dodgson and colleagues identified five challenges associated with the improvement of global health governance.⁴³ This section looks at these five challenges and proposes solutions.

I. NORMATIVE FRAMEWORK

The first, and perhaps the most fundamental, is the need to agree the normative framework upon which GHG [Global Health Governance] can be built. There is a need to reach some degree of consensus about the underlying moral and ethical principles that define global health cooperation.⁴⁴

World Vision believes that an overall framework for engagement in global health is necessary, and that the **right to health** should serve as the cornerstone.

The right to health, as formulated in the WHO constitution and other international treaties (International Covenant on Economic, Social and Cultural Rights, 1966;⁴⁵ Convention on the Rights of the Child, 1989⁴⁶) could provide a starting point, as it is ‘the only perspective that is both underpinned by universally recognized moral values and reinforced by legal obligations’.⁴⁷

Using the right to health as the basis for a normative framework does not have to lead to a commitment to fill a bottomless pit, if one acknowledges only a few of its inherent principles, which include

- the principle of **‘progressive realisation’**, which entails that the highest attainable standard must consider scarcity of resources
- the principle of **‘national primary responsibility’**, which entails that all states are first and foremost responsible towards their own inhabitants
- the principle of **‘core content’**, which entails that all people are entitled to a minimum level of health efforts, even if they live in a country that is too poor to provide this for them without assistance.

Combining those principles while agreeing on a handful of benchmarks allows us to elaborate a basic normative framework: the 193 member states of the WHO would have to agree on the national primary responsibility of all member states towards their inhabitants first, and then on the complementary responsibility of donors towards countries unable to realise even the minimum level of the right to health.⁴⁸

As Hunt and Backman argue, the right to health ‘does not make the absurd demand that a comprehensive, integrated health system be constructed overnight’, but ‘[r]ather, for the most part, human rights require that states take effective measures to progressively work toward the construction of an effective health system that ensures access to all’.⁴⁹

2. LEADERSHIP AND AUTHORITY

A second challenge is the need to define leadership and authority in GHG. ...[H]ealth cooperation has evolved into an arena populated by a complex array of actors operating at different levels of policy and constituencies, with varying mandates, resources and authority.⁵⁰

The pre-eminent role of the World Health Organization

When the WHO was established in 1946 by the UN, it was set up 'to act as the directing and coordinating authority on international health work';⁵¹ however, it has not been given the requisite powers to fulfil that role. Nor has it been given adequate funding as resources in recent years have become more targeted, leaving significant areas under-resourced.

Some argue that the WHO, along with the 'one country, one vote' governance at the WHA, does not reflect the world as it really works. If improving global health governance is seen as an effort to coordinate international assistance for health only, perhaps the countries providing the bulk of international assistance for health should have the predominant voice.

However, global health governance is about total global health efforts, domestic and international, and it is essentially about cooperation and partnership. The WHA is the only place where Ministers of Health from 193 countries come to discuss and decide upon global health policies and standards. This strengthens WHO's continuing mandate to act as convenor, coordinator and standard setter for global health policies, as each country has a voice regardless of its size or power in the world. Even the poorest nations can attend and speak as their attendance is supported through the WHO budget. (Kickbusch discusses this in her 2009 article 'Moving Global Health Governance Forward'.)⁵²

Reflecting on this reality at the 128th Executive Board meeting of the WHO, held in January 2011, member states clearly agreed that global health governance (especially in relation to development, norms and standards, global health security and emergencies) should be a priority for the WHO.

Proposal of a multi-stakeholder forum

At the end of the 128th Executive Board meeting, the Director-General of the WHO proposed a 'plan for strengthening WHO's central role in global health governance, comprising a proposal to hold a regular multi-stakeholder forum (the first in May 2012, subject to the guidance of the World Health Assembly); a proposed process for addressing other aspects of global health governance, possibly also including an overall framework for engagement in global health.'⁵³

World Vision believes that this approach – which in fact contains two different but related proposals, a regular multi-stakeholder forum and an overall framework for engagement in global health – could be an answer to some of the challenges identified by Dodgson and colleagues. We support the concept of a forum but along with others believe that such a group should not have decision-making power but be tasked with making recommendations to the full executive board and WHA each year.⁵⁴

3. SUFFICIENT RESOURCES

A third challenge for GHG is the need to generate sufficient resources for global health cooperation and distribute them appropriately according to agreed priorities.⁵⁵

Global solidarity: Is there value in developing a global health charter?

At present there are insufficient total resources to provide basic health services for all people,⁵⁶ and this is the product of both underinvestment by many low-income countries and insufficient international assistance from many donor countries.

While African heads of state, in the Abuja Declaration, made a commitment to allocate 15 per cent of their budgets to health,⁵⁷ ten years later only two countries have achieved this.⁵⁸ Overall low-income countries have increased their expenditure on health from 7.9 per cent of total government expenditure in 2000 to 8.7 per cent in 2007.⁵⁹

Donor countries in total provided around US\$21 billion in health aid in 2009.⁶⁰ World Vision estimates that this needs to increase to around \$37.5 billion in 2012 and \$42.5 billion in 2015.⁶¹ Some donors are providing their fair share of the aid required, while others are providing much less.

One strategy to resolve this problem is for all nations to agree to a normative framework under which countries hold each other to account for providing their fair share of a common effort, through a peer review mechanism perhaps, as recently adopted in the WHO's regional committee for Africa.⁶²

A normative framework would enable mutual accountability, encouraging governments of all countries to give higher priority to global health, as every individual country would understand that the compliance of all others is at stake should it decide to opt out. Without such a framework, a regular multi-stakeholder forum could easily become a stage for sterile debates between donor and recipient countries about who is not making enough effort.

To resolve this and other problems, Gostin and colleagues propose 'a more formalized, highly effective global compact, which might take the form of a Framework Convention on Global Health', which would clarify global health priorities, as well as national and international responsibilities.⁶³

Some argue that ‘Framework Convention’ sounds too much like a legally binding treaty and governments will try to keep it as unambitious as possible. They are in favour of a non-binding charter. Others argue that if the framework of engagement sets out from the beginning to be non-binding, it won’t be possible to hold governments to account, as they promise only to ‘try’, not to ‘succeed’. World Vision believes that any agreement needs to cover both donor and developing countries as they both have responsibilities for global health.

At this stage World Vision believes that the idea of a Framework Convention deserves further investigation. Undertaking this task could be an action for the global health council.

4. EFFECTIVE ENFORCEMENT MECHANISMS

Fourth, the sovereignty of states is also a hurdle to giving ‘teeth’ to global health initiatives because of the lack of effective enforcement mechanisms. With the exception of the International Health Regulations, which in itself is highly circumscribed in remit, WHO can recommend rather than command action by member states.⁶⁴

There are, at present, no clear responsibilities for governments or non-state actors when it comes to contributing to global health. The right to health provides a foundation but would require further articulation and refinement. The Paris Declaration on Aid Effectiveness commits countries and organisations to seek progress on a set of principles including national ownership, harmonisation, managing for results and mutual accountability. But it lacks precise commitments on which governments could hold each other to account with regard to volume of aid and domestic contributions, and quality of spending.⁶⁵

Thinking about enforcement when precise commitments are lacking seems a senseless exercise. A normative framework based on the right to health, including more precise targets for national and international fair shares, must be part of the solution. Other commitments made in the Paris Declaration on Aid Effectiveness would then have more teeth.

However enforcement may not be the only solution. Severino and Ray argue for ‘shifting the focus away from rules and norms of “harmonization” towards processes of convergence’.⁶⁶ Rather than looking for enforcement, perhaps we should be looking for the right incentives.

The regular multi-stakeholder forum and the overall framework for engagement in global health would not constitute an effective enforcement mechanism as such, but if the forum includes all the major actors (directly or through representatives of larger constituencies), it could agree on incentives for convergence.

There is a broad consensus that the creation of additional global health mechanisms or the dismantling of existing mechanisms should not be on the agenda at present. Some of the respondents to the interviews conducted by World Vision believe that, among existing organisations, the IHP+ has potential to promote support to develop comprehensive long-term health plans, as in the long run, these help to align international assistance. The IHP+ constitutes a global health regime, where a 'regime' is understood as a combination of 'implicit or explicit principles, norms, rules and decision-making procedures around which actors' expectations converge in a given area of international relations'.⁶⁷ An increasing number of developing countries have bought into the IHP+.⁶⁸

Other respondents argued that an organisation or a network of organisations tasked with implementation of the framework would still be needed to provide the necessary incentives. Although donor countries are not likely to agree to channel all their aid through such a mechanism, they may agree to channel a substantial part of it through such an organisation, and that would facilitate mutual accountability under an agreed governance mechanism.

To summarise their arguments: the options include a global health regime, and the IHP+ can be considered as such a regime. But if we fear that some governments may try to dodge their agreed responsibilities, a global health organisation or a combination of global health organisations may work better. Table 2 on the following page summarises features of a global health regime and features of global health organisations, and it compares how they could react to problems or opportunities that may occur. Organisations can do things a regime cannot do. However, World Vision believes that it is unlikely that all health aid would ever be managed by global health organisations, and therefore both organisations and a regime will continue to be needed.

Table 2. Comparing a global health regime with a global health organisation

Problems or opportunities	A global health regime (like the IHP+)	A global health organisation (like GAVI/GFATM)
	Countries agree on mutual responsibilities, alignment with national plans, inclusion of civil society in the elaboration of national health plans, but ultimately conclude agreements between a developing country and a series of donor countries.	Countries agree on mutual responsibilities, alignment with national plans, inclusion of civil society in the elaboration of national plans; donor countries send their contributions to an organisation tasked with the execution of the agreement.
A donor country does not live up to its commitments.	There's not much a regime can do, except denouncing the country not honouring its commitment.	There's not much an organisation can do, except denouncing the country not honouring its commitment. However, known examples of effective burden sharing of international assistance over time all involve organisations. ⁶⁹
A developing country refuses to include civil society in the elaboration of national health plans.	A regime can inform donor countries and advise them to consider the problem, and eventually reduce contributions, but it requires concerted action.	An organisation can consider the proposals from this country as non-eligible.
A developing country does not honour its national responsibility, or cannot account for earlier grants received.	A regime can inform donor countries and advise them to consider the problem, and eventually reduce contributions, but it requires concerted action.	An organisation can freeze donor contributions to this country.
A low-income country is not particularly popular with donors, for reasons unrelated to its national health plan.	A regime can encourage donor countries to help this 'donor orphan', but cannot require they do so.	An organisation can ignore the unpopularity of a given country, and rely on its own internal procedures.
All countries agree on a solidarity levy on international financial transactions, centralised in a Global Solidarity Fund. ⁷⁰	A regime cannot receive funding from a Global Solidarity Fund; it can at best indicate which countries should receive funding from a Global Solidarity Fund, if such a fund is willing and able to finance individual countries.	An organisation can receive funding from a Global Solidarity Fund, and propose its own accountability procedures to satisfy the conditions of a Global Solidarity Fund.

Source: Krasner, 'Structural Causes and Regime Consequences' ⁷¹

5. MORE PLURALIST, YET COHESIVE


Finally, the enigma of how to achieve a more pluralist, yet cohesive, system of global health governance stands before us. As the globalization of health continues, health governance will have to become broader in participation and scope.⁷²

The proposal to hold a regular multi-stakeholder forum may signal the WHO's willingness to become more inclusive and pluralist, but it tells us nothing about how the WHO will balance coordinating actors 'working on an equal footing' and preserving its core function of setting norms for itself and others. Improved global health governance will require a pluralist arrangement to include all the crucial global health actors while at the same time fostering cohesion among those actors.


The WHO is an example of an institution that has normative legitimacy but lacks credibility as a decision-making body: as long as global health is seen as a donor-recipient relationship, donors do not feel bound by rules set by the WHO. This may change if global health is seen as a joint effort based on mutual responsibilities and commitments. As the delegation from Switzerland to the Executive Board of the WHO argued, the WHO should 'be the convener and facilitator of coordination between actors working on an equal footing in addition to WHO's core function of setting norms and standards to be applied by all global health actors'.⁷³

Some of the stakeholders interviewed by World Vision shared the concerns of the People's Health Movement, which states that the forum would be tantamount to 'proposing that WHO play a peripheral role (rather than set the agenda) in global health governance' and sees the forum as preparing for 'actors with commercial interest sharing policy-making and governance platforms'.⁷⁴ A multi-stakeholder forum, these respondents argue, would legitimise unrepresentative influences.

Those in favour of Director-General Chan's proposal argue that the WHO must adjust to new realities. That does not mean, however, that those in favour of the forum agree on how it should be composed. At one extreme, some propose that the forum should include only governments and should emulate the 'one country, one vote' principle of the WHA as faithfully as possible, while aiming for fewer members to facilitate discussions. For example, the six regions of the WHO could organise themselves as constituencies, delegating three persons or countries each. The proponents of such a forum argue that it is the only way to avoid undermining the authority of the WHO and the WHA. At the other extreme, but for very similar reasons, others argue that the forum should include all actors except governments. The aim would be to make it clear that the forum has no authority and should not legitimise the influence of the members.



World Vision calls for the recognition of a shared responsibility to ensure the progressive realisation of the highest attainable standard of health for all people, regardless of where they happen to be born.



Many, including World Vision, feel that both extremes would miss the point that governments cannot achieve equity in health for all people worldwide on their own and that other stakeholders merit representation alongside governments.

The idea of an inclusive advisory forum again prompts very diverse ideas about what it could look like. Some envisage a truly open forum, with hundreds if not thousands of participants. Such a forum could be held annually in March or April and focus its agenda on resolutions proposed by the Executive Board (in January) and provide feedback to the WHA (in May). Distilling representation from so large a group is likely to be difficult and is not in line with WHO's mandate and role.

Others, including World Vision, favour a more formal forum, or a global health governance council, composed of representatives of wider constituencies. The agenda of the WHA is packed already; if one wants the WHA to seriously consider recommendations from the forum, such recommendations should be limited to a handful per year (and that requires at least an ability to vote on which recommendations should be sent to the WHA). At present such a forum is within WHO's role and mandate as it is able to establish working groups to improve its decision-making processes.

Proponents of a more formal advisory forum point to existing efforts to bring governments and other stakeholders together as examples to be considered, such as the Commission on Information and Accountability for Women's and Children's Health,⁷⁵ or the board of the Partnership for Maternal, Newborn & Child Health,⁷⁶ to name but two. These organisations have brought together governments and other stakeholders; most of them expect their members to represent broader constituencies.

And then there is the option of doing both: a GHP forum, open to all, and a global health governance council, composed of 20 to 30 representatives of broader constituencies. Such a proposition could float ideas within the broader forum and then further filter discussions at the level of the council before sending recommendations to the WHA, where decisions can be made. Ultimately, however, World Vision believes that the broadly representative global health governance council is the more workable solution.

Global health today is more understood as a global challenge, on par with other global challenges that require coordinated cooperation among sovereign countries. Imagining the forum as hosted by the WHO, chaired by the WHO, and feeding into WHO and WHA processes, it could significantly strengthen the role of the WHO. World Vision believes that the establishment of a global health governance council with around 30 elected members from representative health stakeholders, one that could feed recommendations to the WHA each year, would be a significant step towards improving global health governance.

Conclusion and Recommendations

The imperative to improve global health governance stems from the continued reality that current resources are inadequate and/or poorly utilised to meet the challenge of addressing the preventable deaths of women and children. World Vision calls for the recognition of a shared responsibility to ensure the progressive realisation of the highest attainable standard of health for all people, regardless of where they happen to be born.

World Vision believes that the structure of global health governance should recognise the leadership and authority of the WHO to coordinate the effective participation of all major stakeholders in setting the normative framework, establishing standards, encouraging further commitments, promoting compliance and highlighting gaps in efforts to promote improved health outcomes.

In line with these commitments, World Vision proposes the following recommendations:

URGENT RECOMMENDATIONS

- World Vision supports Director-General Chan's proposal to create a regular multi-stakeholder forum but suggests that such a forum be set up as a smaller, more robust **global health governance council**,⁷⁷ composed of a limited number of elected representatives from wider constituencies.
- The global health governance council should
 - feed into existing consultation and decision-making processes of the WHO
 - be based on the progressive realisation of the right to health
 - be chaired by the WHO
 - aim to expedite the development of a non-binding **global health charter** that emphasises shared responsibility, mutual accountability and alignment of international assistance with developing countries' priorities. This charter would help to shape agreement on global health and improve cooperation and solidarity between stakeholders.
 - consider the results of the final report of the OECD's Task Team on Health as a Tracer Sector for opportunities at country level to promote the effectiveness of international and domestic resources through mechanisms such as the International Health Partnership (IHP+).
- World Vision calls on the WHO to coordinate current efforts to address global health governance with the work of the Commission on Information and Accountability for Women's and Children's Health and the related accountability framework that will be presented to the WHA.

LONGER-TERM RECOMMENDATIONS

- The global health governance council should
 - investigate the positive and negative impacts of working towards a more binding global health convention that clarifies global health priorities, as well as national and international responsibilities, in line with the right to health
 - investigate the optimal composition of a global health regime and its relationship with global health organisations to implement and monitor the adherence to the global health charter (and convention, if agreed).

World Vision believes that the structure of global health governance should recognise the leadership and authority of the WHO.

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