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The global health architecture – for the benefit of all?

PERSPECTIVES

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Cooperation across national borders is a prerequisite for health security. The World Health Organization was established as an instrument to cope with cross-border health risks, to negotiate norms and standards, and to create a common basis for sharing information, knowledge and resources. Today this role is being challenged by diverse stakeholders and initiatives. The health situation is also affected by numerous intergovernmental processes that are not governed by the health authorities.

Illustration Supernøtt Popsløyd

Institutions, organisations and cooperation and decision-making structures that link different stakeholders together in a more or less established relationship with the health of the world population as their main goal, are often referred to together as «the global health architecture» (1).

Similarly, one can speak of a national health architecture with institutions, stakeholders and decision-making processes that are geared towards health objectives for the national population. The global health architecture cannot be viewed in isolation from the national, nor the national from the local. Many stakeholders and interests are represented at all levels. At the same time each level has its own dynamic and must be understood within its own context.

Neither the global nor the national architectures are static entities; new stakeholders, needs and demands continuously appear. Far-reaching reforms take place in the relationship between public and private, financing structures, synergies and delegations, professions and markets. In addition, there are large differences globally between the needs and interests of countries, while there is no unifying global governing body with the authority to make overall decisions.Architecture, as the art of construction, reflects its time and connects ideas and functionality into a unified structure that will stand the test of time. The global health architecture also reflects its time. The World Health Organization was the first structure, with cooperation between nation-states as its fundamental concept. Since then, numerous stakeholders and interests have come on the scene and have rapidly erected a large number of structures over a relatively short period – without any clear site planning for renewal and,renovation and without an overriding vision to ensure functionality in the architecture.

The big question is whether we have sufficiently good tools to set the agenda, coordinate the different stakeholders and manage the political, technical and economic cooperation to cope with the health challenges that the world faces.

What characterises the global health challenges?

The basis for global health is that all people without exception should have the right to the services, technologies and knowledge that meet their needs to maintain and improve their health. Health is understood as fundamental to peace and security, the safety of society and the social economy, and is dependent on optimal cooperation between individuals, civil society and government.

States have differing abilities to improve the health of their populations and control disease, and the weakest links can create a particular health risk for all countries. The recognition of our shared vulnerability creates a greater understanding of our shared responsibility. At the same time, we can see that public authorities alone cannot create health security, either nationally or globally. Social and economic determinants of health are increasingly influenced by multinational private business activity, migration and communications. Public authorities, the private sector and civil society have a joint responsibility for global health.

It is increasingly clear that health risks can become global extremely fast– thanks to closer cross-border communications, globalised industry and finance and major climate changes. We need a specialised intergovernmental health organisation at the core of the global health architecture, but this is not sufficient as a tool for universal health – since coping with health risks, and decisions pertaining to health, also touches upon areas of policy that are extensively influenced by other stakeholders and other intergovernmental processes.

Arenas and stakeholders

The WHO's constitution, adopted in 1946, began with an emphasis on infectious diseases (2). During the Cold War, it became an important goal to establish the best possible protection against any undesirable «politicisation» of health issues. The constitution has since been updated several times and now sets out a far broader framework of principles for intergovernmental cooperation.

As the UN's specialised agency for health, the WHO has central functions in normative areas, in health oversight, global knowledge management and capacity building for national health management in developing countries. A special feature of the WHO is its organisation through six strong regional offices with considerable autonomy. They have 60 to 70 per cent of the WHO's resources available to them and also have chief responsibility for the WHO country offices.

The WHO is at the absolute centre of intergovernmental negotiations on standards and agreements. The International Health Regulations (2005) (3), the Pandemic Influenza Preparedness Framework (2011) (4) and the Global Code of Practice on the InternationalRecruitment of Health Personnel (2010) (5) are examples of important breakthroughs in these types of negotiations.

But other UN organisations also have important functions in the area of global health. The UN Population Fund (UNFPA) has a particular responsibility for reproductive health and population policy, while the UN International Children's Fund (UNICEF) has child health as part of its mandate. The UN's work to combat AIDS is coordinated through a joint secretariat for the relevant UN organisations (UNAIDS), which monitors the development of the HIV epidemic and provides global leadership in this area. The World Bank, the International Monetary Fund (IMF) and regional banks are important in setting framework conditions and providing funding for health systems in developing countries.

From primary health services to specific health objectives

International health work in the 1990s was mainly concerned with development assistance, headed by the WHO, UNICEF and UNFPA, along with large national development programmes with the USA (United States Agency for International Development), the UK (Department for International Development), Germany (Deutsche Gesellschaft für Internationale

Zusammenarbeit), the Netherlands and the Nordic countries at the forefront. Primary health services were in focus. Emphasis was put on child health, vaccination and reproductive health, and increasingly on health reform and coordinated health sector commitments, with the WHO and the World Bank in leading roles.

However, the results were not convincing. Around the turn of the millennium there was widespread impatience to achieve specific goals. The WHO saw the need for new policy measures, and helped to launch several weighty new initiatives, among them Roll Back Malaria (RBM) and the GAVI vaccine alliance. In this way, new stakeholders from both the private and the voluntary sectors became involved. The UN Millennium Declaration with its three health-related Millennium Development Goals (child health, maternal health and a collective goal for AIDS, tuberculosis and malaria) created fertile ground for a particular mobilisation to achieve these goals. A separate political declaration on HIV and AIDS was adopted by the UN in 2001, and the UN Secretary General involved himself in the proposal to establish a separate fund to deal with this challenge. The G8 countries took this further at their meeting in Okinawa. This was the basis for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) which was established in 2002.

GAVI and GFATM both have substantial resources at their disposal and have produced results that have convinced donors. They are now sought after partners for countries in need of development assistance. Today they are independent foundations registered in Switzerland, with their own executive boards on which national representatives sit together with representatives from the private sector and civil society stakeholders, including user representatives. Both have committed to working within the normative frameworks of the UN system. At the same time, many are worried that the one-sided emphasis on vaccination and on certain diseases has led to insufficient priority being given to investments in infrastructure, personnel and other fundamental elements of a health system.

Private actors such as the Bill & Melinda Gates Foundation have gained importance with regard to financing, prioritisation and choices for global health. The need to create synergies and a common understanding among different stakeholders was the basis for the informal cooperative entity known as H8 (6), where the leadership from the WHO, UNICEF, UNFPA and UNAIDS meet together with the World Bank, GAVI, GFATM and the Gates Foundation. The significance of this entity is still unclear, since it is a forum that is not subject to oversight, does not have the improvement of global synergies as its goal, and does not make binding decisions.

In working with the Millennium Development Goals and with annual reports (7) and resolutions (8) pertaining to the link between foreign policy and health, the UN General Assembly and the UN Secretariat have become an increasingly important actor in the sphere of health architecture, as witnessed by the Secretary General's Global Strategy for Women's and Children's Health (9).

For the last ten years, the G8 countries have channelled much of their development assistance through global initiatives such as GAVI and GFATM. This has led to other donor countries also prioritising these channels. At the

same time, civil society stakeholders and the private sector have had the opportunity to participate on executive boards and to influence decisions, which they do not have an opportunity to do in the WHO. Private foundations and non-governmental organisations have thus obtained an important role in financing and controlling health programmes.

Spin-offs

In the wake of the success of the larger initiatives, new partnerships and alliances have come about for particular purposes, such as the International Drug Purchase Facility (UNITAID), the Partnership for Maternal, Newborn & Child Health (PMNCH), the partnership for health information (Health Metrics Network) and the Global Health Workforce Alliance (GHWA). The main task of most of these alliances is to mobilise different stakeholders towards common goals, but they are not financing entities. Many of the partnerships are hosted by the WHO but have their own executive boards. Spin-offs from such initiatives have created a tendency for every new concept to generate a new partnership, and this has since become a considerable challenge for the WHO.

It has proven very complicated to gain an overview of the resources through the different channels for global health efforts. The organisations register their financing in different ways, and it is not easy to interpret the figures. Some concern transfers for development assistance to poor countries, other figures cover investment in health globally, including the operation of the organisations. According to a recently published article (10), it is clear that the USA alone is the largest stakeholder, while the resources provided through the UN system and financial institutions are not insignificant compared to the large GAVI and GFATM funds. The lack of an overview of financing is a great challenge in terms of governance and streamlining in an architecture of which there is no clear picture.

A need to connect with other arenas

Only the member states of the UN can be part of its governing bodies. Whereas the health ministers are in the driving seat in the WHO, it is the ministries of foreign affairs that look after national interests in UN funds and programmes, and in the UN's General Assembly, councils and committees. In the international financial institutions, the ministries of finance or national central banks are in charge. Member states must therefore have a clearly defined relationship to health in all policies, including how the different ministries can contribute to common goals and coherent policy in different arenas. For precisely this reason, several countries have elaborated their own national strategies for global health, anchored at government level (11).

Health diplomacy is becoming an important part of both health and foreign policy (12). Migration, conflicts and crises create health challenges that require new international solutions. The right to health is bound up with negotiations and agreements about other human rights. Nutrition/food security are included in negotiations regarding the whole food chain and of the work of many

international institutions. Access to medicines is a particularly challenging topic for health diplomacy in international trade negotiations. These areas of policy present considerable challenges linked to national and international cooperation regarding methods, interests and power. Therefore there is also a need in the health architecture for institutional relations with intergovernmental institutions, both within and outside of the UN system, that do not have health as their primary mandate.

Governance challenges in the global health architecture

The WHO's position as the authority for directing and coordinating international health work is strongly challenged today, both in terms of financing and organisation (13). The large number of stakeholders, budgetary pressures, increasing emphasis on results and broader cooperation between government, non-government and private entities is forcing a discussion about how the WHO-based intergovernmental efforts can be managed in a better way, with better links to other arenas and processes. In this regard, new ways of thinking and work on reform are taking place in the WHO, in the various global health initiatives and in a broader dialogue on global governance of intergovernmental cooperation. (14).

The principles set out in the WHO's constitution are, however, still well suited as a frame of reference for a more effective global health architecture including a more effective UN. There is general agreement on the justification and relevance of the WHO as the «core» of the health architecture and as the chief arena for intergovernmental collaboration on health objectives through negotiations and binding cooperation. The question is how this core is positioned in the interplay with multiple non-state stakeholders and initiatives that can contribute resources, innovate, and serve as driving forces for overcoming dysfunctions and building synergies for results.

The challenge is not primarily a more unified global health architecture, but greater attention to what currently hinders the efficient management of resources and results-oriented collaboration between different stakeholders and arenas. This is a time to embrace diversity and combine forces for results. Innovation and renewal must seek simplification and functionality in the architecture, better informed by agreed norms and objectives and with clear mutual accountabilities both between governments and across non-state actors at national and global level.

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