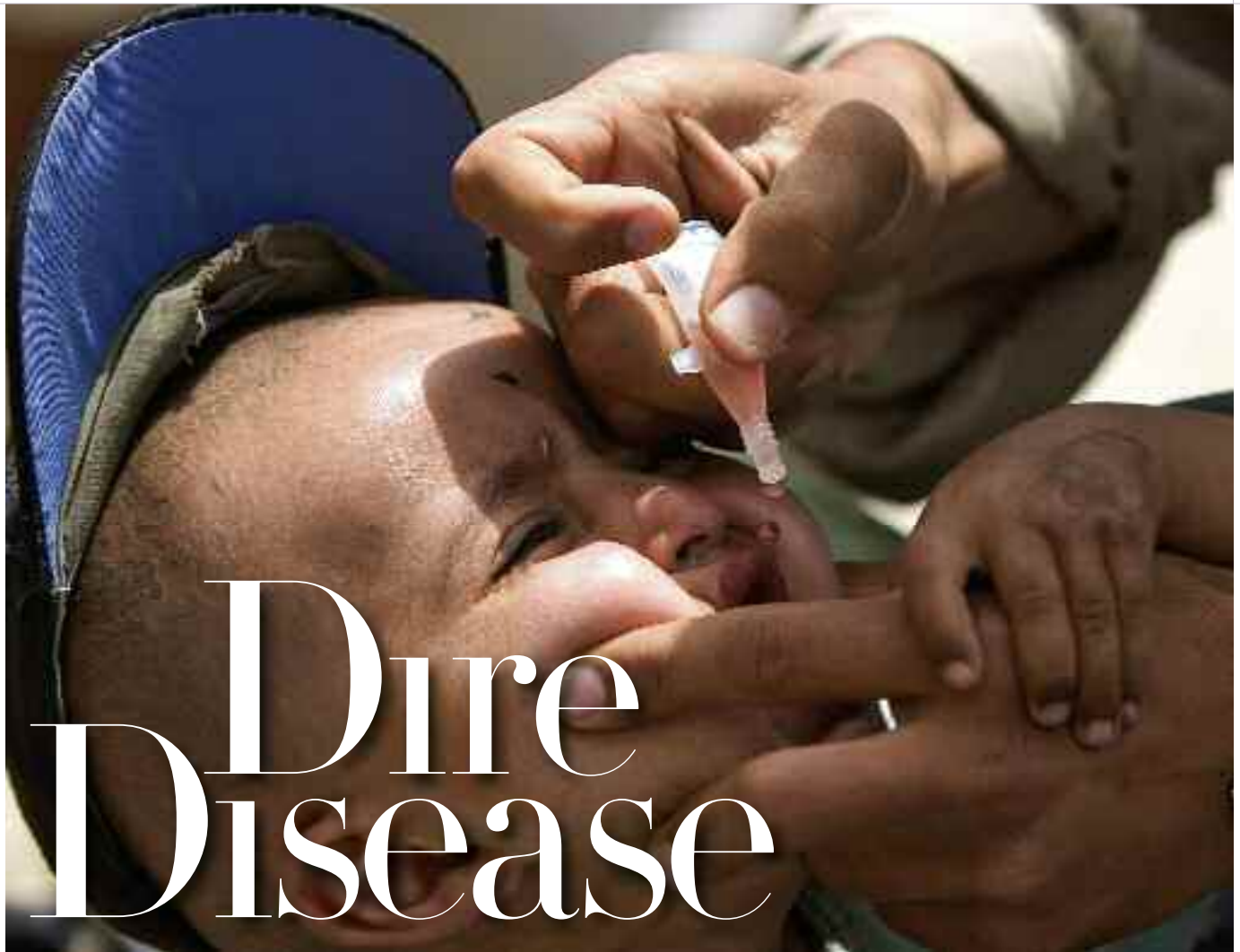


GLOBAL HEALTH – WHO CAN LEAD?

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Dire Disease

Global health is in a dire state. Annually, almost ten million children die before the age of five. The top four childkillers are diarrhoeal disease, malaria, malnutrition, and upper respiratory infection. In the next 24 hours diarrhoea, caused by unclean water and poor sanitation, will claim the lives of four thousand children. Two and a half billion people still have no access to even the most rudimentary latrine. More than one billion have no source of drinking water. It only costs \$1 to vaccinate against measles, yet one child dies of the disease every minute in Africa. Measles infects thirty to forty million children each year and kills over 410,000. Who is leading globally to address these problems?

IT SEEMS THAT THE MAIN RESPONSIBILITY FOR GLOBAL health should lie with the United Nations specialist agency, the World Health Organization (WHO), established in 1948 to aid all peoples in the attainment of the highest possible level of health. It was created to be the chief director and coordinator of global health. However, since its inception, and especially over the past two decades, the

WHO has become increasingly marginalised because of three significant changes in the global health system.

TOO MANY PLAYERS, TOO MANY INITIATIVES

The past fifteen years have witnessed an explosion in the number as well as type of actors involved with health. Since its 1993 World Development Report Investing in Health, and arguable even since 1980, the World Bank has become the most influential global health actor in the UN. This reflects its financial power as a lender, its access to senior decision-makers in ministries of planning and finance and reputation for intellectual prowess.

Other than the WHO and World Bank, there has been an exponential growth of civil society organisations and of the private sector in global health, as well as increasing involvement by charitable foundations, research institutes, regional development banks, regional organisations, such as the European Union, and various partnerships and networks.

In addition to the increase in the number of players, there has been a constant deluge of initiatives, focusing on specific diseases or issues, such as the United States President's Emergency Plan for AIDS Relief (PEPFAR), STOP TB, Roll Back Malaria, UNAIDS, the H-8, and most recently the International Health Partnership. While some of these have been housed in the WHO, the vast majority exist entirely outside, such as the Joint UN Programme for HIV/AIDS.

GO-IT-ALONE BILATERAL AID

The second trend has been a move away from multilateral aid towards bilateral health programmes. This has been driven largely by the administration of former President George Bush. In 2002, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria was established to serve as a financial instrument, managing and providing resources through an independent, technical process. A year later, Bush launched PEPFAR, the \$15 billion five-year plan for AIDS relief which is the largest ever bilateral health programme to target a particular disease. Funds were allocated to fifteen countries chosen by the Bush administration, the large majority in sub-Saharan Africa.

Last July, PEPFAR was re-authorized with \$48 billion to be spent by 2013. While PEPFAR has done an enormous amount of good, it operates entirely outside the UN system and only allocates a small proportion of funding to the Global Fund.

The move away from multilateral cooperation seems also to be occurring in emerging powers, such as China, India and Brazil. These countries show a tendency to use regional, plural or bilateral mechanisms to engage in global health, rather than relying solely on the WHO.

GATES EMPIRE

The third change in the global health system has been the incredible increase in the amount of money pledged for global

health, rising from a few hundred millions in the early 1990s to an estimated \$20 billion last year. Other than the US government, the most significant new player is the Bill & Melinda Gates Foundation which, with the donation from Warren Buffet, is the global health donor with the largest endowment, roughly \$67 billion, and with annual disbursements of roughly \$3 billion. This compares with the WHO's biennial funding of \$3.3 billion for 2006-2007.

The Gates Foundation has been donating an enormous amount of money to global health, resulting in almost every university department, think-tank, civil society group and partnership working in this area, receiving funding from it directly or indirectly.

This generosity has extended even to the UN system: while thirty percent of the WHO's budget is funded by assessed member contributions – roughly half a billion – the remaining seventy-five percent is from extra-budgetary funds from member states and philanthropic bodies. Alongside the US and British governments, the Gates Foundation is the third largest contributor to the WHO.

One of the consequences of a limited pool of donors with an increase in the number of actors and initiatives, is competition among the various parties, for the same pots of money. As a former health minister in sub-Saharan Africa noted, 'Everyone is chasing the money-reputable universities, the UN agencies, partnerships, civil society groups, so who is actually doing what developing countries really need, rather than what donors want?'

Much of the increase in funding has been directed at HIV/AIDS, malaria and tuberculosis. A recent study of the four biggest donors noted that in 2005, funding per death varied widely by disease, from \$1029.10 for HIV/AIDS to \$3.21 for non-communicable disease. The result is that while indicators for certain targeted diseases shows striking improvement, in some situations, primary care has deteriorated and other less 'fashionable' diseases, such as child diarrhoea, have gone unnoticed.

Most of the new money pouring into poorer countries is radically skewing public health and medical programmes towards the issues of greatest concern to the donors, but not necessarily of top priority for people in recipient states.

STRENGTHENING WHO?

The question then of who leads on world health is not an easy one to answer. Many experts argue that there is no single leader, nor strategic vision for where the global health community should be going. While the WHO was created to be the lead agency, a number of factors have eroded its ability to be the focal institution.

Some hope that with the change in US administration, there will be renewed use of multilateral mechanisms and political commitment to reform and strengthen existing UN bodies. While it is far from perfect, there seems little doubt that the WHO should be the leader; and given certain reforms, it could manage the chaotic and crowded landscape and play a key role as coordinator.

