

Governance and Financing of Global Public Health: The Post-2015 Agenda

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FIFTEEN YEARS AGO, IN THE wake of rising concerns over the lack of progress in reducing global poverty, the UN adopted the Millennium Development Goals (MDGs).¹ All 189 United Nations Member States committed themselves to eight goals aimed at reducing global inequities between developed and developing countries by addressing the needs of the world's poorest and most vulnerable populations. The MDGs aimed to eradicate extreme poverty and hunger, achieve universal primary education, improve child and maternal health, combat the spread of HIV/AIDS and other diseases, ensure environmental sustainability, promote gender equality, and enhance the governance of development by means of financial reforms benefitting heavily indebted poor countries.² Progress on some goals has been impressive: the target of halving the proportion of people whose income is less than \$1 USD a day was achieved in 2010, five years ahead of the 2015 deadline. The target of halving the proportion of people who lack dependable access to improved sources of drinking water has also been met.³

Overall progress, however, has been “patchy” and “uneven,” with “insuf-

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ficient” and “sluggish” progress, particularly in sub-Saharan Africa and South Asia.⁴ The current global economic crisis also threatens future progress given that fiscal constraints are already jeopardizing the realization of the MDGs. Furthermore, fragmentation and lack of cohesiveness among donors financing health-related MDGs have promoted vertical approaches to planning, programs, monitoring, and reporting, such as those for HIV/AIDS and malaria, that are not sufficiently integrated with national health systems.⁵

In this paper, we examine some of the larger shifts in the governance and financing of global public health and their ramifications for post-2015 progress. In particular, we look at the rise of the emerging economies, the move towards multi-bi financing, the proliferation of health institutions, the demographic shift, and finally the growing movement towards universal health coverage as the focal point of post-2015 efforts.

TREND 1: RISE OF THE EMERGING ECONOMIES

As we move into the second decade of the twenty-first century, a shift in global power towards the emerging economies (particularly Brazil, China, and India) has become more obvious. In the past, certain high-income countries such as the United States, the United Kingdom, France, Germany, and Japan had inordinate influence in setting the global agenda—both through their funding decisions and through their leverage in international institutions such as the World Bank, International Monetary Fund, and even the World Health Organization (WHO). Consequently, governance was driven by the traditional powers of the Global North—especially Western Europe and North America. These states had a set of interests that were often at odds with low- and middle-income countries, including trade liberalization.⁶

But the power dynamics are beginning to change in a newly multipolar political climate.⁷ New social, economic, and political alignments are evident, for example, in the emerging health leadership of countries such as Brazil, India, Mexico, and Thailand, which are at the forefront of pushing universal health coverage and implementing demonstrable modeling of universal health insurance. These nations are reluctant to be constrained by the “traditional” powers. The growing economic and political strength of developing countries, especially the BRICS—Brazil, Russia, India, China, and South Africa—manifests itself in their increasingly active role in development cooperation and is driving innovations in global governance.⁸ In November 2011, for example, these players largely drove the shift from aid effectiveness to development effectiveness going

into the Fourth High Level Forum on Aid Effectiveness in Busan, South Korea.⁹

As global health takes a more central place in foreign policy—embedded in concerns for security, trade, development, and humanitarian relief—it has featured in diplomatic negotiations at the highest levels.¹⁰ Today, global health can be found on the agendas of major power structures such as the G8 and the UN General Assembly. Major global health decisions were once the province of dominant powers in Europe and North America. Today, however, power blocs from the Global South, with a very different set of social, economic, and political interests, provide a counterpoint to the traditional powers, which historically reserved their strongest global health efforts for issues that impacted their own security.

The Foreign Policy and Global Health (FPGH) Initiative, which “seeks to promote the use of a health lens in formulating foreign policy to work together towards common goals,” draws its leadership largely from the South, consisting of five southern (Brazil, Indonesia, Mexico, Senegal, and Thailand) and two northern (France and Norway) countries.¹¹ South-South health cooperation is increasingly occurring through regional alliances, such as the 12-nation South American Health Council, aimed at strengthening health systems, controlling infectious diseases, and negotiating fair prices for essential medicines.

What does the rise of the emerging economies mean for smaller developing countries?¹² A useful perspective can be gained by evaluating whether there has been any significant transition of key financial global decision-making from the G8 to the G20, especially given the evidence suggesting waning interest by the former. Health did not make the cut in either the 2011 or 2012 G8 agendas.¹³ The G8 is largely composed of “like-minded” countries with similar strategies on how to improve health. In the past, the group has played an important role in financing global health through formal commitments, creating new institutions, and prioritizing certain issues on the global stage (such as global health as foreign policy and human security).¹⁴ For example, the G8 was the driving force behind the creation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, whose members still contribute a large portion of its funding. Similarly, Japan took advantage of its leadership of the G8 to use the 2008 Toyako summit to push for health systems strengthening. And in 2005, under the leadership of the United Kingdom, the G8 committed to achieving universal access to antiretrovirals for those living with HIV/AIDS. Despite hope from the health

As global health takes a more central place in foreign policy, it has featured in diplomatic relations at the highest levels.

community that the G20 would play a similar role, it has yet to step up to tackle health in a significant way.¹⁵ Thus, having more countries in international negotiations does not automatically translate to better action and implementation of policies concerning the world's poor.

How have the emerging economies specifically engaged with global health? While these countries, particularly the BRICS, have been vocal and influential in financial discussions, they have had a more limited impact so far in global health. For example, the fact that the relatively economically stable BRICS have not increased their financial contributions to the Global Fund has raised questions about their commitment to global health leadership in the long term.¹⁶ Therefore, while it is clear that the emerging economies are becoming more influential in global governance, it does not follow that the interests of poorer countries or even public health concerns will be advanced. When these countries do engage, their approach seems to be issue-specific. Examples include debates on access to essential medicines, technological cooperation, or the Trade-Related Aspects of Intellectual Property Rights (TRIPs) agreement. Interestingly, all of these have as much to do with trade as with health. Furthermore, where these countries engage seems to be driven by regional concerns, which also explains the re-invigoration and creation of regional bodies in health such as IBSA (India, Brazil, South Africa) and UNASUR (Union of South American Nations). The post-2015 agenda will need to fit with both the internal and external strategic interests of the emerging economies. This might be realized through post-MDG frameworks containing universal goals with nationally negotiated and differentiated targets.

TREND 2: RISE (AND FALL) OF MULTI-BI FINANCING

Driven by popular concerns about HIV/AIDS, maternal mortality, and the H1N1 flu pandemic, global health has experienced an exponential increase in resources.¹⁷ Initially, the rise in funding looks like increased support for multilateral cooperation through agencies like the WHO, the World Bank, or a number of new multi-stakeholder initiatives such as the Global Fund. The WHO biennial budget has more than doubled in the past decade from \$1.6 billion in 1998–1999 to \$4.5 billion in 2010–2011. Within the World Bank's activities in health, total commitments have increased from \$1.7 billion in 1998–1999 to \$4.7 billion in 2010–2011. But a closer look at these numbers tells a different story.

Within both of these agencies, core budgets are flat or fluctuating. Almost all

of the growth is attributable to increases in discretionary funding, or “multi-bi” aid. The Development Assistance Committee at the Organisation for Economic Co-operation and Development (OECD-DAC) estimates that about 30 percent of the multilateral funding is given through what it calls “multi-bi” aid. This term refers to the practice of donors choosing to route non-core funding, earmarked for specific sectors, themes, countries, or regions through multilateral agencies.¹⁸ At first glance the funding appears multilateral, but upon further investigation, multi-bi aid is essentially controlled by a bilateral donor. Examples of multi-bi aid include voluntary contributions within the WHO, trust funds within the World Bank, the Global Fund, and the GAVI Alliance.

Within the WHO extra-budgetary funding has risen from 48.8 percent in 1998 to 1999 to 77.3 percent in 2008 to 2009. The core funding of the WHO is used for the purposes decided by member states of the World Health Assembly, while specific donors decide the use of extra-budgetary funding. Within the World Bank’s activities in health, total commitments have increased from \$1.7 billion USD in 1998 to 1999 to \$5.2 billion in 2006 to 2007. While growth has occurred in both types of funding, it is the trust fund portfolio for health that has experienced the most dramatic growth from \$95 million in 2003 to 2004 to \$2.4 billion in 2006 to 2007, which is almost equal to the \$2.8 billion core funding provided through the International Bank for Reconstruction and Development (IBRD) and International Development Association (IDA). The budgets reveal that a significant proportion of increased funding for global health has come from contributions that are discretionary in terms of amount and timing of payment to fund a specific activity as opposed to the general purposes of the organization and to fund implementation through a third party.

But that is not the entire story. Alongside increases in discretionary, earmarked funding in existing multilateral agencies, the emergence of new multi-stakeholder global health funding institutions such as the Global Fund and the GAVI Alliance has signaled a major change in global cooperation. The Global Fund is fast becoming one of the largest donors in health with pledges rising from \$852 million in 2001 (its creation) to \$3.2 billion in 2010. While these initiatives have been referred to as “multilateral” because more than two states participate in their governance, they differ in five important ways from the WHO and World Bank.¹⁹ First, their boards include voting rights for the Bill & Melinda Gates Foundation, the private sector, nongovernmental organizations, and member states. Second, they have narrow problem-based mandates that are clearly measurable, such as number of children vaccinated, bed nets distributed, or persons on antiretroviral medication. Third, they must raise their entire bud-

gets through voluntary contributions and receive no core funding. Fourth, they have no country presence but rather work through governments, multilateral partners, and local organizations. And finally, they claim their legitimacy through effectiveness in improving specific health outcomes rather than being an inclusive and deliberative forum for countries across the world. Thus, these initiatives

More global health institutions and initiatives have been created and launched in part because of the historical inability of the WHO to respond adequately. are characteristically different in form and governance and reflect the shift towards “Trojan multilateralism,” the process whereby increased funding to multilateral institutions is creating the illusion of multilateral intent while covertly introducing bilateral goals and interests into multilateral institutions.²⁰

Since 2002, global health donors have increasingly prioritized multi-bi aid at the expense of more traditional forms of multilateral aid as a proportion of all development assistance for health.²¹ Multi-bi aid increased as a proportion of all aid at a rate of approximately 1.5 to 2.0 percentage points per year from 2002 to 2009.²² Bilateral aid as a share of total development assistance for health has remained stable over this time period.

74 The movement toward multi-bi aid has reversed since the onset of the global financial crises with donors decreasing their contributions to GAVI, the Global Fund, and UNAIDS since 2008.²³ This effect is particularly true of the ten largest global health donors, where this channel of funding decreased by nearly 6 percent of all development assistance for health during 2008–2009. This indicates that donors prefer to fund global health through channels that are easier to budget for on a yearly basis. Post-2015 goals and the resulting mechanisms and channels will need to fit with this pattern or follow a more radical path to tie donors into multi-year commitments. A shift toward models of annual (or, ideally, multi-year) funding will give countries the stability to better plan and coordinate implementation processes.

TREND 3: INTERNATIONAL PROLIFERATION

Since 2000, more global health institutions and initiatives have been created and launched in part because of the historical inability of the WHO to respond adequately to emerging challenges. This is illustrated graphically, for example, by the need to create UNAIDS to tackle the emergence of HIV and the Global Fund’s launch in 2002, built on the precedent created by UNAIDS.²⁴ GAVI was

also created in October 1999 to overcome deteriorating global immunization rates and achieve wider access to existing or new vaccines for the world's poor, partially because of the failure of existing immunization programs within the WHO.²⁵ New multi-stakeholder, multi-sector partnerships in global governance have been particularly influential. At the start of her term in 1998, WHO Director-General Margaret Chan acknowledged that the WHO was facing serious competition from other institutions with greater power, influence, and dispensable resources in global health.²⁶ Additionally, corporations and private philanthropic organizations like the Bill and Melinda Gates Foundation, Rockefeller Foundation, Warren Buffett, and Bloomberg Philanthropies have committed unprecedented billions of dollars to multi-stakeholder organizations combating global disease. These stakeholders are reconstituting governance processes by assuming greater decision-making power at the executive level and are no longer perceived merely as financial donors. The Bill and Melinda Gates Foundation's representation on the boards of GAVI and the Global Fund (with voting rights), for example, gives the Foundation a status equivalent to a range of UN agencies. Indeed, the Foundation is present in three of the Health 8's (H8) eight partners. H8 is a group of health-related organizations created in 2007 to foster a sense of global urgency for achieving the health-related MDGs.

Collaborative working groups have been celebrated as evidence of progressive dialogue, policy integration, transparency, compromise, and commitment between different interest groups seeking to improve the health of the world's most vulnerable populations. However, they remain largely uncoordinated and focused on vertical disease-specific programs, and they have not been subject to rigorous assessment.²⁷ They may also give rise to perceptions of conflicts of interest.²⁸ Initiatives designed to support coherence among global players, such as the International Health Partnership (IHP+) and H8, have remained largely focused on vertical global health program delivery rather than taking a role in leading governance for health as a global public good.²⁹ Additionally, collaboration in global health is being openly embraced despite the fact that some global partnerships have collapsed due to high levels of distrust and corrosive competition between partners (e.g. the Children's Vaccine Initiative).³⁰ For example, the infighting between WHO and UNICEF was a major contributor of the demise in 1999 of the Children's Vaccine Initiative, which was originally established in 1990 among an alliance of UN agencies, private foundations, and industry to improve vaccination programs for the world's poorest children.³¹

A post-2015 arrangement should consider alternative platforms for key stakeholders to collaborate on shared goals with the WHO in order to use re-

sources more effectively, promote innovation and inter-organizational learning, and develop a more coordinated response to overcome political bottlenecks. However, any arrangement would require willingness on the part of the WHO to accept more flexibility in its agenda-setting procedures, greater acceptance of the changing environment and thus the need for external collaboration among some of its staff, and respect for the autonomy and decision-making authority of each self-governing entity at the bargaining table. Additionally, given that evidence and monitoring systems for the effectiveness of cross-sector partnerships are essentially nonexistent, frameworks for evaluating collaborative efforts could also be built into new accountability models for multi-stakeholder institutional development.³²

In addition to coping with numerous new actors, both new and traditional health institutions must recognize that health is also affected by the policies of non-health sectors. The WHO and other global health agencies, while accepting the concept of Health in All Policies, presently lack the resources and mechanisms to meaningfully participate in policy issues like trade, security, and climate change.³³ Subsequently, the political prioritization of health becomes lost within issue areas like environmental protection, food security, and trade.³⁴ New governance and accountability mechanisms should invoke multi-sector collaboration as well as diverse stakeholder participation on health issues. Multi-sector participation has already begun on health issues at the state level through inter-ministerial working groups focused on global health, the reduction of health inequities, and HIV/AIDS prevention in Australia, Canada, India, Norway, Sweden, Switzerland, Thailand, Uganda, United Kingdom, and the United States.³⁵ Institutional incentive structures to engage other sectors in negotiations about health are crucial to raising the profile of health-related priorities in other policy communities at all levels of governance.

Given that the impact of multi-stakeholder partnerships is comparable at micro- and macro-levels of governance, with crucial implications for organizational learning and innovation, a post-2015 agenda should advance the MDGs by examining the nature of partnerships, their mechanisms, internal structures, and outcome effects in order to improve practice and coordination among global health actors.³⁶ In particular, the agenda should encourage a coordinating body to oversee organizational initiatives and ensure alignment with country-level health systems goals and planning for universal health coverage.

TREND 4: THE BURDEN OF NON-COMMUNICABLE DISEASES

Within this changing institutional and geopolitical environment, there has also been a transition in health-related demographics. Non-communicable disease (NCD), primarily cardiovascular disease, cancer, chronic respiratory disease, and diabetes, caused 63 percent of all mortality in 2008—a considerable increase from 40 percent in 1990, the MDG base year.³⁷ Africa is the only region where NCDs are not the leading cause of death, but even here they are projected to overtake all other causes within the next 20 years.³⁸ Over 80 percent of NCD-related deaths occur in low- and middle-income countries, with lower socioeconomic groups affected the worst in terms of morbidity, mortality, and loss of economic opportunity.³⁹ These data do not even account for the health and economic costs of the major burden of mental illnesses.

The often chronic and debilitating course of NCDs means that they significantly impact social and economic development, deepening inequality.

The increased burden of NCDs is not simply a consequence of population aging. Indeed, rates of cardiovascular disease are falling rapidly in many rich countries. A major factor for this rise in NCDs is the increased penetration of markets in many low-income nations by globalized food, tobacco, and alcohol industries, whose products contribute to increased risks for several chronic conditions.⁴⁰ One consequence is the emergence of obesity as a significant risk factor for many chronic diseases in several middle-income regions such as North Africa, Oceania, and the Middle East; the widespread marketing of sugar-rich drinks has been a major driver in this trend.⁴¹ In terms of disability burden, NCDs comprise between 62 to 92 percent of all years lost to disability (YLDs). In 2010 (the most recent year for which data was collated in the Global Burden of Disease study), the major risk factors were high blood pressure, tobacco smoking, and alcohol use, replacing two of the top three in 1990, malnutrition and indoor air pollution (with tobacco smoking remaining).⁴²

The often chronic and debilitating course of NCDs means that they significantly impact social and economic development, deepening inequality and setting up a cycle of disability and health costs-related poverty.⁴³ Both the complexity and urgency of the epidemic were recognized by recent high-level summits, including the UN meeting on NCDs in September 2011, which endorsed a political declaration on the international response required to combat the crisis.⁴⁴ The World Health Assembly in March 2012 also adopted a target

to reduce early mortality from NCDs by 25 percent by 2025.⁴⁵ The lack of explicit inclusion of NCDs in the MDG framework is one area that requires a significant reconfiguration in any post-MDG agreement, and the importance of primary prevention will have to take center stage.

Two key environmental shifts have also emerged in the global discourse as crucial determinants of health.⁴⁶ First, the evidence for anthropogenic climate change has strengthened considerably.⁴⁷ Although the health impacts of a warming planet remain controversial, any new global governance framework will have to address this issue. The WHO has already adopted a climate change and health work plan encompassing scientific research, advocacy, collaborative inter-agency working, and health systems strengthening.⁴⁸ Second, urbanization continues apace: in 2010 urban dwellers outnumbered rural dwellers globally for the first time. Asian countries, most notably China and India, have accounted for 65 percent of global urban growth since 2000, and although the proportion of the world population living in slums is declining, absolute numbers have increased.⁴⁹ As with climate change, urbanization is likely to deepen health and socioeconomic inequalities in those communities with the fewest resources for handling these shifts, requiring global funding and strategies for adaptation.⁵⁰

78 **TREND 5: FROM VERTICAL PROGRAMS TO HEALTH SYSTEMS TO UNIVERSAL HEALTH COVERAGE**

In 2012 critical momentum for universal health coverage (UHC) emerged in high-level political circles. In April 2012 Mexico hosted a forum on *Sustaining Universal Coverage* involving WHO and delegates from 21 countries.⁵¹ This resulted in the Mexico City Political Declaration on UHC emphasizing universal coverage as “an essential component of sustainable development” and its inclusion as “an important element in the international development agenda.”⁵² In June 2012 a larger gathering met in Rio de Janeiro, Brazil for the Rio+20 Summit on sustainable development. Despite initial reticence, the Rio+20 resolution explicitly recognized UHC in the aspiration “to strengthen health systems towards the provision of equitable universal coverage.”⁵³ Later in 2012, a WHO Discussion Paper on the Post 2015 health agenda identified UHC as a “way of bringing all programmatic interests under an inclusive umbrella.”⁵⁴ In September 2012 the Foreign Policy and Global Health Group proposed a historic resolution to be tabled for negotiations at the UN to increase global commitment on UHC.⁵⁵ Consequently, on 12 December 2012, the UN General Assembly (including the United States) adopted a resolution on UHC, urging

governments to move towards providing affordable access to quality health-care services to all people, as well as emphasizing the intrinsic role health plays in achieving international sustainable development goals.

UHC's global prominence and widespread endorsement in the post-2015 agenda provides pause to reflect on its apparent absence in MDG negotiations, which occurred not so long ago. Indeed, in the 1990s the literature on UHC was dominated by the health care insurance debate in the United States and the Clinton administration's failed attempts at reform. Statist interpretations of UHC pervaded; UHC was a question of concern in and for the global North. Unlike the pre-MDG period, current processes that seek to identify and formulate new development goals are more ambitious and consultative, evidenced through the UN's mass engagement with civil society in advancing the post-2015 development agenda.⁵⁶ In contrast, the MDGs were identified in a largely technical exercise among a group of UN experts with colleagues from the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD/DAC), the World Bank, and the International Monetary Fund following the release of the Millennium Declaration. Working together and taking a top-down approach to policy development, the group formulated eight measurable development goals drawing from the targets of UN summits and conferences in the 1990s.⁵⁷

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Lauding of UHC in 2012 by state and non-state actors has strengthened the case of UHC's integration into the post-MDG development goal discussion. For many in the global health community the health-related development agenda post-2015 must be centered on UHC and its link to WHO's revitalization of Primary Health Care or the health rights affirmed in the Universal Declaration of Human Rights 1948 (Article 25) and in the International Covenant on Economic, Social, and Cultural Rights 1966 (Article 12). The World Health Assembly officially defined the achievement of UHC in 2005 as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access."⁵⁸ While UHC does offer something more substantial than the MDG silos (which focus on select health priorities), a cautious approach is required since UHC's multiple meanings can result in various stakeholders choosing particular definitions to suit their interests. UHC has been construed, for example, as national service delivery, national service coverage, financial protection, and national health insurance and related reforms. It is unclear what health services UHC covers (e.g., whether it fully covers public health services such as sanitation, vector abatement, and tobacco control), and questions arise over whether UHC includes only services within

a state's health sector or services and interventions outside the health sector.⁵⁹ This is a pertinent point given the interplay between government ministries and departments developing policies and providing services that holistically benefit citizens' health and well-being.

The ambiguity around the meaning of UHC—and thus the lack of its application—has complicated WHO's promotion of the concept. When the organization's World Health Report 2000 identified universalism as the next wave of health systems reform, it omitted a comprehensive definition of universalism. Uncertainty around interpretations of universalism (and by extension UHC) persisted while WHO's 2005 resolution called states to implement a UHC strategy. For example, the contracting out of district-based health services (for instance, in Cambodia, East Timor, and Afghanistan), linked to WHO's backing for UHC (despite the lack of interpretive clarity), led to questioning of the meanings of "coverage" and "quality coverage," while also raising concern about equitable geographic coverage and utilization of available yet poor quality health care services.⁶⁰

Traditional state-centric positioning and application of UHC heighten confusion.⁶¹ Instead, the post-2015 health debate and WHO's advocacy for the highest attainable standard of health for all through UHC is likely to shift the statist use of this concept to a globalist one. In other words, UHC is moving from traditional state-centric meanings to a more world-centric (and a somewhat ironic yet literal universal) strategy.⁶² UHC's emerging global-centric characterization was also affirmed in the General Assembly's historic adoption in

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Baselines for achievement of universal health coverage must be agreed upon and developed in post-MDG negotiations and adapted to country circumstance.

December 2012 of a resolution that emphasizes promotion of UHC in the global health and foreign policy context, wherein the UN and Member States are called to look at the application

of UHC not only within borders, but beyond borders at regional and global levels (e.g., in terms of geographical coverage, equity, health workforce mobility, and notably brain drain from low resource settings, as well as issues regarding medical tourism).

While there is merit in UHC's globalist form, there is nonetheless a real risk that UHC will be undermined by statist interpretation and implementation, echoing experiences arising from the formulation of the MDGs.⁶³ How the UN resolution will be put into practice in 2013 and beyond is the crucial question: "universal coverage is much more difficult to achieve than to advocate."⁶⁴ The

application of standard targets and health agendas inappropriate to country contexts and realities has been a key lesson from the MDGs. Flexible, culturally acceptable, country and context-specific application of UHC that ensconces community priorities and is fully owned and operated by national governments is important: as WHO's Director-General Margaret Chan states, "Every situation is unique. Every solution must be tailor-made."⁶⁵ And the fact that UHC has to be re-defined in each specific situation, that priorities have to be set, and that resources have to be allocated may be an advantage because it requires a political process and dialogue involving stakeholders at the local level. However, if UHC is to become a new development goal, then baselines for achievement of UHC must be agreed upon and developed in post-MDG negotiations and adapted to country circumstance, fiscal realities, and community priority.

CONCLUSIONS

This paper has examined shifts in the governance and financing of global public health over the past 15 years. The following five key issues will have ramifications for post-2015 progress:

Geopolitics

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While it is clear that the emerging economies are more influential in global governance, it does not follow that the interests of poorer countries or even public health will be advanced. When these countries do engage in global health governance, it seems that their approach is issue-specific, such as for access to essential medicines, technological cooperation, or the debate around TRIPs.⁶⁶ The issues in which these countries engage seems to be driven by either trade or regional concerns, with the latter explaining the re-invigoration and creation of regional bodies in health. The post-2015 agenda will need to fit with the internal agendas in the emerging economies and their broader, strategic, external interests that seem to focus on sustainable development issues of climate change, energy, and clean water sources.

Financing

The evidence on financing reveals that a significant proportion of increased funding has come from contributions that are discretionary in terms of amount and timing of payment, funding a specific activity as opposed to the general

purposes of the organization, and implementation through a third party. This indicates that donors prefer to fund global health through channels that are easier to budget for on a yearly basis. Post-2015 goals and the resulting mechanisms and channels will need to fit with this pattern or follow a more radical path to tie donors into multi-year commitments.

Institutions

The proliferation of well-resourced public–private partnerships for health has significantly reconstituted traditional forms of global health governance that were typically led by the WHO. Post-2015 arrangements should extend the aims of MDG 8 by creating a platform for prominent global health organizations to communicate their priorities with one another and the WHO, pool resources, align strategies for delivery and evaluation, share learning, and foster innovation that benefits country-led health planning priorities.

Demographic and Environmental Shifts

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Challenges in health merit explicit inclusion in any new framework. In particular the NCD crisis—along with the underlying social determinants of health—requires greater emphasis, and addressing the health effects of climate change must be prioritized. The separate dialogues on climate change, energy, and global health need to be brought together into an integrated and multi-sector discussion on the future of global governance.

Universal Health Coverage

While UHC offers more substantial breadth than the MDG silos, which elevate select health priorities, its multiple meanings have resulted in various stakeholders choosing particular definitions to suit their interests. While there is merit in UHC's globalist form, there is nonetheless real risk that UHC will be undermined by statist interpretation and implementation. If UHC is to become a new development goal, then baselines for achievement must be agreed upon and developed in post-MDG negotiations as well as adapted to country circumstances, fiscal realities, and community priorities.

These five developments need to be taken into account as we move forward into the Sustainable Development Goal era. 

NOTES

1. We would like to acknowledge the insights gained from discussions at the Go4Health workshop in Heidelberg. We would also like to acknowledge a much shorter version of the paper focused exclusively on noncommunicable diseases that was published in *PLoS Medicine*.
2. United Nations, *Road map towards the implementation of the United Nations Millennium Declaration: Report of the Secretary-General Document A/56/326* (New York: United Nations, 2001); Carmen Ungurean, "Millennium Development Goals," in *Public Health Strategies: A Tool for Regional Development*, ed. Silvia Gabriela Scintee and Adriana Galan (Lage, Germany: Hans Jacobs Publishing Company, 2005), 142–49; Natasha Krishnadas, "Millennium Development Goals," *Medical Student Journal of Australia* 1 (2009): 36–38.
3. United Nations, *The Millennium Development Goals Report 2012* (New York: 2012).
4. Jeff Waage, et al., "The Millennium Development Goals: a Cross-Sectoral Analysis and Principles for Goal Setting after 2015," *Lancet* 376, no. 9745 (2010): 991–1023.
5. Ibid.
6. Gregg Bloche Maxwell and Elizabeth R. Jungman, "Health Policy and the WTO," *Journal of Law, Medicine and Ethics* 31, no. 4 (2003): 529–45; David Harvey, *A Brief History of Neoliberalism* (Oxford: Oxford University Press, 2005); Laurence R. Helfer, "Regime Shifting in the International Intellectual Property System," *Perspectives on Politics* 7, no. 1 (2009): 39–44; Joost Pauwelyn, "The End of Differential Treatment for Developing Countries? Lessons from the Trade and Climate Change Regimes," *Review of European, Comparative & International Environmental Law* 22, no. 1 (2013): 29–41.
7. Peter S. Hill, Scott Brown, and Just Haffeld, "Effective Aid in a Complex Environment," *Bulletin of the World Health Organization* 89, no. 12 (2011): 854–54A.
8. Nkunde Mwase and Yongzheng Yang, "BRICs' Philosophies for Development Financing and Their Implications for LICs," IMF Working Paper 12/74, 2012.
9. European Union, *The Role of BRICS in the Developing World* (Directorate General for External Policies of the Union, 2012).
10. Katherine E. Bliss, "Introduction," in *Key Players in Global Health: How Brazil, Russia, India, China and South Africa are Influencing the Game*, ed. Katherine E. Bliss (Washington, D.C.: CSIS Global Health Policy Center, 2010).
11. Margaret Chan, Jonas Gahr Store, and Bernard Kouchner, "Foreign Policy and Global Public Health: Working Together Towards Common Goals," *Bulletin of the World Health Organization* 86, no. 7 (2008): 498; Celso Amorim, et al., "Oslo Ministerial Declaration—Global Health: A Pressing Foreign Policy Issue of Our Time," *Lancet* 369, no. 9570 (2007): 1373–78.
12. Ngaire Woods, et al., *Transforming Global Governance for the 21st Century*, United Nations Development Program, 2013.
13. Amanda Glassman, "What happened to health at the G-8?" Center for Global Development, March 21, 2012; Devi Sridhar, "Will global health break the back of the G20?" *Global Health Policy* (blog), August 5, 2010.
14. Michael R. Reich and Keizo Takemi, *The G8 and Global Health: Emerging Architecture from the Toyako Summit* (Tokyo: International Conference on Global Action for Health System Strengthening, 2008).
15. *What is next for the G20? Investing in health and development* (conference paper, The Royal Institute of International Affairs, London, 2010).
16. Katherine Bliss, *Key Players in Global Health: How Brazil, Russia, India, China and South Africa are Influencing the Game* (Washington, D.C.: Center for Strategic and International Studies, 2010).
17. Devi Sridhar, "Who Sets the Global Health Research Agenda? The Challenge of Multi-Bi Financing," *PLoS Medicine* 9 (2012).
18. Ibid.
19. Ibid.
20. Devi Sridhar and Ngaire Woods, "Trojan Multilateralism: Global Cooperation in Health," *Global*

Policy (forthcoming).

21. Karen Grepin and Devi Sridhar, "Multi-Bi Aid and Effects of the 2008–10 Economic Crisis on Voluntary Development Assistance for Health Contributions: A Time Series Analysis," *Lancet* 380 (2012).

22. Ibid.

23. Amanda Glassman, "What Happened to Health at the G-8?"

24. Peter Piot, *No Time to Lose: A Life in Pursuit of Deadly Viruses* (London: W.W. Norton, 2012).

25. Scott Wittet, "Introducing GAVI and the Global Fund for Children's Vaccines," *Vaccine* 19 (2001): 385–86.

26. Laurie Garrett, "The Challenge of Global Health," *Foreign Affairs* (January/February 2007); Chatham House, *What is Next for the G20? Investing in Health and Development* (London: The Royal Institute of International Affairs, 2010); Katherine Bliss, *Key Players in Global Health: How Brazil, Russia, India, China and South Africa are Influencing the Game* (Washington: Center for Strategic and International Studies, 2010); Karen Grepin and Devi Sridhar, "Multi-Bi Aid and Effects of the 2008–10 Economic Crisis on Voluntary Development Assistance for Health Contributions: A Time Series Analysis," *Lancet* 380 (2012).

27. Tim Unwin, *Partnerships in Development Practice: Evidence from Multi-Stakeholder ICT4D Partnership Practice in Africa* (Paris: UNESCO, 2005).

28. David Stuckler, Sanjay Basu, and Martin McKee, "Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest Be Addressed?" *PLOS Medicine* 8, no. 4 (2011).

29. Ilona Kickbusch, *The 10 Challenges of Global Health Governance* (Global Health Europe, 2010).

30. William Muraskin, "Last Years of the CVI and the Birth of the GAVI," in *Public-Private Partnerships for Public Health*, ed. Michael Reich (Cambridge: Harvard University Press, 2002): 115–69.

31. Helen Gavaghan, "UN to End Children's Vaccine Initiative," *Science* 283, no. 5410 (1999): 1992–93.

32. Katherine Bliss, "Key Players in Global Health: How Brazil, Russia, India, China and South Africa are Influencing the Game" (Washington, D.C.: Center for Strategic and International Studies, 2010); Peter Piot, *No Time to Lose: A Life in Pursuit of Deadly Viruses* (London: W.W. Norton, 2012).

33. Timo Ståhl, et al., *Health in All Policies: Prospects and potentials* (Helsinki: Ministry of Social Affairs and Health, Finland and European Observatory on Health Systems and Policies, 2006).

34. Laurie Garrett, "The Challenge of Global Health," *Foreign Affairs* (January/February 2007).

35. Dawn Primarolo, Mark Malloch-Brown, and Ivan Lewis, "Health is Global: A U.K. Government Strategy for 2008–2013," *Lancet* 373 (2008): 443–44; Tone Torgersen, Øyvind Giæver and Ole Trygve Stigen, "Developing an Intersectoral National Strategy to Reduce Social Inequities in Health: the Norwegian Case" (Oslo, 2007); Joan Anderson and David Garmaise, *Towards a Broader View of Health: Strengthening Inter-Ministerial Collaboration on HIV/AIDS in Canada* (Ottawa: Ministerial Council on HIV/AIDS, 2001); Canada's Federal Initiative to Address HIV/AIDS, *Federal Initiative to Address HIV/AIDS in Canada: Implementation Evaluation Report* (Ottawa: 2009).

36. Ted London, Dennis Rondinelli, and Hugh O'Neill, "Strange Bedfellows: Alliances Between Corporations and Nonprofits," in *Handbook of Strategic Alliances*, ed. Oded Shenkar and Jeffrey Reuer (Thousand Oaks: Sage, 2005); John Selsky and Barbara Parker, "Cross-Sector Partnerships to Address Social Issues: Challenges to Theory and Practice," *Journal of Management* 31 (2005): 849–73.

37. Ala Alwan, *Global Status Report On Noncommunicable Diseases 2010* (Geneva: World Health Organisation, 2011); Christopher J. Murray and Alan D. Lopez, "Mortality By Cause for Eight Regions of the World: Global Burden of Disease Study," *Lancet* 349 (1997): 1269–76.

38. World Health Organization, *The Global Burden of Disease: 2004 Update* (Geneva: World Health Organization, 2008).

39. Ala Alwan, *Global Status Report on Noncommunicable Diseases 2010* (Geneva: World Health Organisation, 2011); Commission on the Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Actions on the Social Determinants of Health* (Geneva: World Health Organization, 2008).

40. David Stuckler, "Population Causes and Consequences of Leading Chronic Diseases: A Comparative Analysis of Prevailing Explanations," *Milbank Quarterly* 86 (2008): 273–326; David Stuckler, et al., "Manufacturing Epidemics: The Role of Global Producers in Increased Consumption of Unhealthy Commodities Including Processed Foods, Alcohol, and Tobacco," *PLoS Medicine* 9, no. 6 (2012).

41. Sanjay Basu, et al., "The Relationship of Soft Drink Consumption to Global Overweight, Obesity

- and Diabetes: A Cross-National Analysis of 79 Countries,” *American Journal of Public Health* (2013): 1–7.
42. General Assembly of the United Nations, *Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases* (New York: United Nations, 2011).
43. World Health Organization, Commission on the Social Determinants of Health (Geneva: World Health Organization, 2008); Martin Suhrcke, et al., *Economic Consequences of Non-Communicable Diseases and Injuries in the Russian Federation* (London: European Observatory on Health Care Systems, 2007).
44. World Health Organization, *Prevention and Control of Noncommunicable Diseases: Outcomes of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control* (Geneva: WHO Secretariat, 2010).
45. David Stuckler, Sanjay Basu, and Martin McKee, “Drivers of Inequality in Millennium Development Goal Progress: A Statistical Analysis,” *PLoS Medicine* 7, no. 3 (2010).
46. Kathryn J. Bowen and Sharon Friel, “Climate Change Adaptation: Where Does Global Health Fit in the Agenda?” *Globalization and Health* 8, no. 10 (2012).
47. Susan D. Solomon, et al., *Climate Change 2007: The Physical Science Basis* (Fourth Assessment Report of the Intergovernmental Panel on Climate Change, 2007); Martin Parry, et al., *Climate Change 2007: Impacts and Vulnerability, Contribution of Working Group II to the Fourth Assessment Report of the Intergovernmental Panel on Climate Change* (Cambridge: 2007).
48. World Health Organization, *Climate Change and Health* (Geneva: the Secretariat, 2009).
49. United Nations Human Settlement Program (UN Habitat), *State of the World’s Cities 2012/2013: Prosperity of Cities* (Nairobi: United Nations, 2012); United Nations, *The Millennium Development Goals Report 2012* (New York: United Nations, 2012).
50. Martin Parry, et al., *Climate Change 2007: Impacts and Vulnerability. Contribution of Working Group II to the Fourth Assessment Report of the Intergovernmental Panel on Climate Change* (Cambridge: 2007).
51. Forum on Universal Health Coverage, *Mexico City Political Declaration on Universal Health Coverage* (Mexico City: World Health Organization, 2012).
52. Ibid.
53. United Nations, RIO +20 Conference, *The Future We Want* (Rio de Janeiro: 2012).
54. World Health Organization, *Positioning Health in the Post-2015 Development Agenda* (2012).
55. Oxfam, *UN Resolution on Universal Health Coverage* (2012).
56. Julia Ravenscroft and Liliana Marcos, “Civil Society Organisations and Universal Health Coverage,” *Lancet* 280 (2012): 888.
57. David Hulme, “The Making of the Millennium Development Goals: Human Development Meets Results-based Management In an Imperfect World” (Manchester: The University of Manchester Brooks World Poverty Institute, 2007); Jan Vandemoortele, “The MDG Story: Intention Denied,” *Development and Change* 42 (2011): 1–21.
58. World Health Assembly, *Sustainable Health Financing, Universal Coverage and Social Health Insurance* (2005).
59. David B. Evans, Justine Hsu, and Ties Boerma, “Universal Health Coverage: Access to What?” *Lancet* 374 (2009): 1946; Victoria Fan, Amanda Glassman, and William D. Savedoff, “A Post-2015 Development Goal for Health—Should It Be Universal Health Coverage?” *BMJ Group Blogs* (2012).
60. Bart Jacobs, et al., “Addressing Access Barriers to Health Services: An Analytical Framework for Selecting Appropriate Interventions in Low-Income Asian Countries,” *Health Policy Plan* 22 (2012): 288–300.
61. Gina Lagomarsino, et al., “Moving Towards Universal Health Coverage: Health Insurance Reforms in Nine Developing Countries in Africa and Asia,” *Lancet* 380 (2012): 933–43.
62. For further discussion on “statist” and “globalist” perspectives, see: Sara E. Davies, “What Contribution Can International Relations make to the Evolving Global Health Agenda?” *International Affairs* 86 (2012): 1167–90.
63. David Hulme and James Scott, “The Political Economy of the MDGs: Retrospect and Prospect for the World’s Biggest Promise,” *New Political Economy* 15 (2010): 293–306.
64. Davidson R. Gwatkin and Alex Ergo, “Universal Health Coverage: Friend or Foe of Health Equity?”

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Lancet 377 (2011): 2160–61.

65. Margaret Chan, *More Countries Move Towards Universal Health Coverage* (Mexico City: World Health Organization, 2012).

66. World Health Organization, *BRICS Health Ministers' Meeting: Beijing Declaration* (Beijing: 2011).

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