HEART
HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: **Health architecture: current and future**

Date: **18.08.2014**

Background: **DFID is mapping the current health architecture and identifying drivers that will influence the future architecture from 2015. This will be used to inform DFID on the strengths and weaknesses of the current architecture, and of the relevance and responsive of the health architecture for the post 2015 agenda.**

Query: **Please provide an annotated bibliography and short summary referenced analysis of the key findings on the health architecture (including global health aid architecture and global health governance) since 2000.**

This work is intended to look at health architecture, health aid and health governance from a global perspective. It is not intended to cover a review of literature on the analysis of instruments/drivers/actors etc. at the country level.

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1. Overview

Since the World Health Organization (WHO) was established over 60 years ago, it has been at the centre of global health governance. HoLIGOC 2008 The WHO's political legitimacy exists because its membership encompasses all countries in the UN. This allows WHO to convene governments and other players to negotiate rules, resolve differences, and reach consensus. Sridhar et al 2014 Member states are also major players, but with varying degrees of influence and involvement. Hoffman & Røttingen 2014 Nonstate actors involved include private foundations, civil society groups, academics, research institutes, global social movements, private companies, private philanthropists, consultancy firms, think tanks, religious movements and even organized crime. Dodgson et al 2002, Szlezák et al 2010

The globalised world faces many health challenges including infections, undernutrition, reproductive health problems, and a rising global burden of noncommunicable diseases. Frenk & Moon 2013 Health is now recognised as being intertwined with sustainable economic development, global security, effective governance, and human rights promotion. Frenk 2010 The global context is changing, with new pressures from climate change and trade policies, which present challenges from outside the traditional health sector. As a global population, there is a great diversity among societies in norms, values, and interests. There is also large inequalities in the distribution of health risks and the resources to address them. Frenk & Moon 2013

Despite unprecedented funding being secured to address health challenges, there is still a significant deficit in resources. Frenk 2010 In particular, it is clear that further funding is needed to improve monitoring and evaluation for all global health activities. Operational research will also need more funding. Moon et al 2010

The original mission of the WHO was to be the world's pre-eminent public health authority and at the same time offer an intergovernmental platform for global health negotiations. Its ability to deliver on this mission is questionable, as its technical and political mandates undermining its ability to deliver. Hoffman & Røttingen 2014 The capacity of national governments to protect its citizens and promote good health has also declined. Dodgson et al 2002 The fragmented efforts of recent years have led to inefficiency. In particular, this is due to the variety of structure and processes in place. Certain players focusing on specific diseases, rather than addressing the wider issues, has also caused problems, leading to inefficiency. Many organisations involved in health have been competing for funding, which is unhelpful to the progression of global health. HoLIGOC 2008

The current architecture is crowded and poorly coordinated. HoLIGOC 2008 Concern about global health has focused attention on global health governance architecture. Fidler 2007 The current system fails to provide sufficient justification for an obligation to assist in meeting the health needs of others. Transnational and national actors too often pursue their own interests. A stronger commitment to all people being healthy is needed. Ruger 2012 It is clear that reform is needed due to a mismatch between governance mechanisms and the vulnerability and complexity of global processes. UNDP 2014 A profound transition of the global health system is already under way. Szlezák et al 2010 With the MDG era coming to an end in 2015, the international community has an opportunity to ensure that post-2015 health priorities reflect the health needs of both current and future generations. Buse & Hawkes 2014 As part of this transition, state and non-state actors must be better connected for transparent policy dialogue in decision-making processes that affect health. Commitments to global solidarity and shared responsibility is needed to move towards a more sustainable and healthy system. Ottersen et al 2014 Those players from the private sector and civil society must be included in the reform process and the governance system that follows. The more transparent the governance system is, the more effective it will be. UNDP 2014

To move forward, roles must be clarified and a vision agreed upon. HoLIGOC 2008 Decisions must be made on leadership and authority. There will also be challenges regarding the funding and resourcing of the governance system. UNDP 2014 A historical analysis of the governance systems from years gone by could be useful to analyse contemporary patterns and relationships. Loughlin & Berridge 2002

There is calls from some quarters to shift the focus of global health governance from infectious disease to noncommunicable diseases, injuries, and mental health. A different approach is also called for to assess public health. Traditional indicators, such as maternal and infant mortality rates, may no longer be suitable to describe societal health status. Health registration and disease specific reporting will be important, with health equity, access, and coverage being prioritised. De Cock 2013 Action should be data-driven, evidence-informed, and results-oriented. Buse & Sidibé 2013

The new global governance system must be based on a legal framework. However, international law is not sufficient to create effective global health governance alone. Fidler 2002 The laws must provide the framework for the improvement of health for everyone, even the most vulnerable. Ill-justified international health laws that dictate poor countries' policies and priorities could prevent serious consideration of initiatives better suited to legal instruments. Hoffman & Røttingen 2012 Structural flaws may restrict the current architecture from fulfilling its purpose. For example, the WHO is undermined by an institutional design that mixes technical and political mandates. If the WHO was divided into two institutions, separating its technical and political stewardship, would create the change needed to improve in the delivery of the

two mandates. Member states and other players would need to be involved in this process. Hoffman & Røttingen 2014 In the globalised world, addressing the global burden of disease, and promoting healthy lives, needs cross-sectoral action. Buse & Hawkes 2014 The new agenda must be integrated with better links to other development architecture. Buse & Sidibé 2013 However, the different agendas of the different players need to be acknowledged and exposed. Many non-governmental organisations (NGOs) are governed from industrialised countries. Poorer countries tend to have the least say in the health agenda. Often local priorities are overlooked, as the states are obliged to pursue global objectives. Hoffman & Røttingen 2012
The AIDS response is an example of a successful public health initiative. In the post-2015 period, planning wider health governance can learn a lot from the success of the AID response, which must remain at the centre of the agenda. Justice, human rights, and gender equality must be the foundations upon which the new agenda is constructed. Transforming global governance for health will require continued investment—but it will be an investment in results. Buse & Sidibé 2013

As discussions around the post-2015 era gain momentum, universal health coverage has emerged as an operational and analytical priority. D'Ambruoso 2013 Despite this consensus around universal health coverage, a report by a panel of 27 experts written to advise the UN on the post-2015 development agenda did not include universal health coverage as a goal or target. UN 2013 This has led to criticism from some quarters, as universal health coverage is regarded as a unifying theme for the global health community. It is feared that the targets and goals that were presented, may lead to different players following different agendas, and thus they will be pitted against each other. Ooms et al 2013 To achieve universal health coverage, attention must be paid to universal access, including coverage for health services (prevention and treatment) and access to coverage with financial risk protection. Vega 2013, Evans et al 2013

Universal health coverage is desirable, but it is argued it should not be the only goal. It is suggested that health goals should be represented by a meaningful health status outcome. Health care is only one of a multitude of factors affecting health, and this needs to be taken into account by those planning the post-2015 agenda. Whatever goals are defined by the process should be measurable across countries. Victora et al 2013

2. Key relevant literature on the current health architecture since 2000.

Shiffman J. A social explanation for the rise and fall of global health issues. Bulletin of the World Health Organization. 2009; 87 (8)
http://www.ncbi.nlm.nih.gov/pubmed/19705011

This paper considers why some global health issues (e.g. HIV) receives significant attention from the international community and national leaders, while others (e.g. malnutrition) remain neglected, despite similar burdens of mortality and morbidity. The author suggests that the rise, persistence and decline of a global health issue can be explained by the way in which its policy community--the network of individuals and organisations concerned with the problem--comes to understand and portray the issue and establishes institutions that can sustain this portrayal. This explanation emphasizes the power of ideas and challenges interpretations of issue ascendance and decline that place primary emphasis on material, objective factors such as mortality and morbidity levels and the existence of cost-effective interventions. Therefore strategic communication is at the heart of what global health policy communities do.

Sridhar D, Frenk J, Gostin L, Moon S. Global rules for global health: why we need an independent, impartial WHO. BMJ 2014; 348
http://www.bmj.com/content/348/bmj.g3841

A budget crisis in 2010 triggered substantial reform of the WHO. At a more fundamental level, deeper systematic changes in global health governance have made reform imperative. The WHO has political legitimacy because its membership encompasses all countries in the UN. This allows the WHO to convene governments and other players to negotiate rules, resolve differences, and reach consensus. As new health challenges arise, the independence and neutrality of the WHO become even more important. The WHO is struggling with finances. Powerful stakeholders are increasingly funding the WHO through voluntary contributions, which now make up 80% of the WHO's total budget. Although the WHO could benefit from additional resources, the greater challenge is that it needs a larger proportion of its budget guaranteed.

Dodgson R, Lee K, Drager N. Global health governance: a conceptual review. Global health governance discussion paper; no. 1. World Health Organization, Geneva, Switzerland. 2002.
http://whqlibdoc.who.int/publications/2002/a85727_eng.pdf

This discussion paper discusses how globalisation may be reducing the capacity of states and other actors to co-operate internationally to protect human health. It has introduced or intensified transborder health risks, including emerging and reemerging infectious diseases, various noncommunicable diseases, and environmental degradation. Globalisation is characterised by a growth in the number, and degree of influence, of nonstate actors in health governance. The relative authority and capacity of national governments to protect and promote the health of domestic populations has declined in the face of globalising forces beyond national borders that affect the basic determinants of health as well as erode national resources for addressing their consequences. Nonstate actors, including civil society groups, global social movements, private companies, consultancy firms, think tanks, religious movements and organized crime, in turn, have gained relatively greater power and influence both formally and informally. At the same time, globalisation appears to be problematic for sustaining, and even worsening existing socioeconomic, political and environmental problems. It also has led to the decline in both the political and practical capacity of the national governments, acting alone or in cooperation with other states, to deal with global health challenges.

Szlezák N, Bloom B, Jamison D, Keusch G, Michaud C, et al. The Global Health System: Actors, Norms, and Expectations in Transition. PLoS Med, 2010; 7 (1)
http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000183

This is the first in a series of four articles that highlight the changing nature of global health institutions. It argues that the global health system is in a state of profound transition. It starts by stating that global health needs to include disease prevention, quality care, equitable access, and the provision of health security for all people. The global health system is defined as the constellation of actors (individuals and/or organisations) whose primary purpose is to promote, restore or maintain health, and the persistent and connected sets of rules (formal or informal), that prescribe behavioral roles, constrain activity, and shape expectations" among them. Such actors may operate at the community, national, or global levels, and may include governmental, intergovernmental, private for-profit, and/or not-for-profit entities. National health ministries and the WHO, who were regarded as the traditional actors of global health are now being joined and held to account by a variety of civil society and nongovernmental organisations, private firms, and private philanthropists. New thinking may be needed on the possibilities of reforming the current global health system. Key considerations include:

- Setting global health agendas in ways that not only build upon the enthusiasm of particular actors, but also improve the coordination necessary to avoid waste, inefficiency, and turf wars.
- Ensuring a stable and adequate flow of resources for global health, while safeguarding the political mobilisation that generates issue-specific funding. How can

the global burden of financing be equitably shared, and who decides? How should resources be allocated to meet the greatest health risks, particularly those that lack vocal advocates?

- Ensuring sufficient long-term investment in health research and development (R&D). Who should contribute, and who should pay? How can the dynamism and capacity of both public and private sectors from North and South be harnessed, without compromising the public sector's regulatory responsibilities?
- Creating mechanisms for monitoring and evaluation and judging best practices—how can policy agreement be achieved when actors bring contested views of the facts to the table?
- Learning lessons from the enormous variance in effectiveness and costs of various national and international health systems, from R&D to the delivery and monitoring and evaluation (M&E) of interventions in the field, to create improvements everywhere.

Frenk J. The Global Health System: Strengthening National Health Systems as the Next Step for Global Progress. PLoS Med, 2010; 7 (1)
http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000089

This is the second in a series of four articles that highlight the changing nature of global health institutions. It argues that health has been increasingly recognised as a key element of sustainable economic development, global security, effective governance, and human rights promotion. As the perceived importance of health grows, unprecedented funding has been secured. Despite this, funding remains insufficient. In recent times there has been a burst of new initiatives coming forth to strengthen national health systems as the core of the global health system and a fundamental strategy to achieve the health-related Millennium Development Goals (MDGs). To capitalise on the opportunities that these circumstances present, a clear conception of national health systems that may guide further progress in global health is needed. The paper concludes with a list of factors that must be considered to improve national health system performance.

Keusch G, Kilama W, Moon S, Szlezák N, Michaud C. The Global Health System: Linking Knowledge with Action - Learning from Malaria. PLoS Med, 2010; 7 (1)
http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000179

This is the third in a series of four articles that highlight the changing nature of global health institutions. This paper traces the evolution of how the global health system addresses malaria through the integration of better research, development, and delivery of new products to treat and control the disease. It extracts lessons applicable to the many new challenges currently facing the global health system. It explores how malaria research has changed over the years and the impact of the delivery of research products to those at risk, including the interactions between the organisations and actors involved.

It concludes that building an effective global health system takes times. Investments in capacity building in other relatively neglected areas, such as non-communicable diseases, must begin today if we expect similar dividends in the future. Research must connect closely to the challenges of implementation. Research and development must be valued by leadership. Organisations need to commit to scaling up research and capacity building. Connections must be built between researchers in the North and the South. The case study of malaria suggests that a multiplicity of partnership models is useful, particularly for diseases that require multiple interventions and continuing research and development. Those who suffer from diseases, those who contribute to R&D, and those who deliver interventions, must share the responsibility to link knowledge with action if the future global health system is to succeed.

Moon S, Szlezák N, Michaud C, Jamison D, Keusch G, et al. The Global Health System: Lessons for a Stronger Institutional Framework. PLoS Med, 2010; 7 (1)
http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000193

This is the fourth and final paper in a series of articles that highlight the changing nature of global health institutions. As well as drawing on the other papers in the series, this paper presents the findings from a study of institutions in the global health system. It argues that in the present complex global environment no single actor can or should set the agenda for action. Global partnerships similar to those that have transformed malaria and the infectious disease agenda will be needed to mobilise resources for other health problems, such as chronic diseases. National health systems must be strengthened if sustainability is to be achieved, as they provide the essential link between global knowledge and best practices, and local health needs and impact. The proliferation of global actors threatens to weaken health systems by placing additional reporting burdens on already thinly stretched health ministries. As new global health initiatives arise to address the wave of emerging health challenges, the global health system should identify and adopt analogous ways to streamline reporting and, more generally, to minimise the additional transaction costs put on countries.

Systematic investment is needed to improve monitoring and evaluation, which is needed for all global health activities. Over time, this investment will contribute to building robust M&E systems and to generating reliable, comparable data to inform action. Long-term investments in education and training at many levels is expected to result in improved health. The global health system should prioritise additional investments in longer-term, multidisciplinary education and training for leadership in the complex public health, medical, management, economic, education, communications, and policy aspects of health systems, and in the functioning of health systems overall. Research that provides the evidence and knowledge bases for prioritisation, resource allocation, and the development and evaluation of new tools and interventions must be invested in. Operational research will be crucial to learning how to use the tools that are available, take them to scale, and engage populations to become co-producers of health rather than passive recipients of services. More broadly, research should be promoted to understand variation in the performance of different national health systems, and thus to identify system designs that can be adapted to local circumstances to help translate global aspirations into meaningful impact on people's lives.

Frenk J, Moon S. Governance Challenges in Global Health. New England Journal of Medicine, 2013; 368
http://www.nejm.org/doi/full/10.1056/NEJMra1109339

The authors argue that global health is at the threshold of a new era. The world faces major challenges including infections, undernutrition, reproductive health problems, and a rising global burden of noncommunicable diseases. In addition, globalisation is resulting in new challenges such as climate change and trade policies, which demand engagement outside the traditional health sector. Addressing these issues is challenging due to the great diversity among societies in norms, values, and interests, as well as by large inequalities in the distribution of health risks and the resources to address them. It will require improved governance of health systems at both the national and global level. To assist with this process, the concept of governance must be better understood.

Ottersen O, Dasgupta J, Blouin C et al. The political origins of health inequity: prospects for change. The Lancet, 2014, 383 (9917)
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2962407-1/fulltext

This paper analyses global health governance and the range of policy areas that affect it. This includes economic crises and austerity measures, knowledge and intellectual property,

foreign investment treaties, food security, transnational corporate activity, irregular migration, and violent conflict. In the contemporary global governance landscape, differing power relationships between actors (who may have conflicting interests) are responsible for shaping political determinants of health. The key messages are:

- The unacceptable health inequities within and between countries cannot be addressed within the health sector, by technical measures, or at the national level alone, but require global political solutions.
- Norms, policies, and practices that arise from transnational interaction should be understood as political determinants of health that cause and maintain health inequities.
- Power asymmetry and global social norms limit the range of choice and constrain action on health inequity; these limitations are reinforced by systemic global governance dysfunctions and require vigilance across all policy arenas.
- There should be independent monitoring of progress made in redressing health inequities, and in countering the global political forces that are detrimental to health.
- State and non-state stakeholders across global policy arenas must be better connected for transparent policy dialogue in decision-making processes that affect health.
- Global governance for health must be rooted in commitments to global solidarity and shared responsibility; sustainable and healthy development for all requires a global economic and political system that serves a global community of healthy people on a healthy planet.

Fidler D. Architecture Amidst Anarchy: Global Health's Quest for Governance. Global Health Governance, 2007; 1 (1)
http://www.repository.law.indiana.edu/facpub/329/

Concern about global health has focused attention on governance questions leading to calls for a new global health governance architecture. This article examines the growing demand for such architecture. The author argues that the architecture metaphor is inapt for understanding the challenges global health faces. As well as the traditional problem of synergising national and global behaviour, a new problem coined as “open source anarchy” has arrived. This is characterised by states and non-state actors resisting governance reforms that would restrict their freedom of action. This is not governance architecture but a normative “source code” that states, international organisations, and non-state actors apply in addressing global health problems, the application of which is revealing deficiencies in national public health governance capabilities. These deficiencies are difficult to address in conditions of open-source anarchy. Governance initiatives on global health are, therefore, rendered vulnerable.

McCoy D, Chand S, Sridhar D. Global health funding: how much, where it comes from and where it goes. Health Policy Planning, 2009; 24 (6)
http://heapol.oxfordjournals.org/content/24/6/407.full

This paper argues that as global health funding has increased in recent years, it has been accompanied by a proliferation in the number of global health actors and initiatives. A schematic describing the different actors and three global health finance functions is used to organise the data presented, most of which are secondary data from the published literature and annual reports of relevant actors. It is suggested that the volume of official development assistance for health is frequently inflated and that data on private sources of global health finance are inadequate. The large and important role of private actors is recognised. The fragmented, complicated, messy and inadequately tracked state of global health finance requires immediate attention. The authors argue that it is necessary to track and monitor global health finance that is channelled by and through private sources, and to critically examine who benefits from the rise in global health spending.

Moon S, Omole O. Assistance for Health: Critiques and Proposals for Change. Chatham House Working Group on Financing Paper 1, 2013.
http://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0413_devtassistancehealth.pdf

In recent years there has been rapid growth in development assistance for health and new institutional forms such as public–private partnerships. Many of these are now under threat as a result of the financial crisis. Low-income countries depend on external sources for one-quarter of their health expenditures. Health challenges are changing. For example the burden of non-communicable diseases in developing countries is now recognised as significant. The growing economies of middle-income countries are increasingly recognised as important. The changing context raises questions as to the appropriate ways of sustaining international support for global health and making it more effective.

This working paper offers proposals for reform, including raising resources through new taxes, e.g. on financial transactions or innovative financial mechanisms; ways of reforming the institutions through which assistance is channelled; and new proposals that go beyond the current system, including the use of international law to codify mutual obligations and new institutions such as a Global Social Protection Fund. Criteria are suggested for assessing reform proposals with a view to providing the foundation for building stronger and more equitable institutions for financing global health.

In the last 10 years there have been significant and rapid change in the system for development assistance for health. The world is now entering an era of major transition. An overview of the system and its major areas of weakness are included in this paper, followed by a review of a broad range of proposals to address them and criteria by which such proposals could be weighed. Many proposals are focused on specific concerns, rather than the bigger picture. This raises two questions: how ambitious should efforts at systemic reform be; and how interconnected are existing problems? If financing and governance arrangements are fundamentally inseparable, can or should they be addressed in an integrated way? The authors argue that while many of the proposals are characterised by a ‘big idea’, they remain nascent and would benefit from more detailed implementation plans. Many proposals are lacking basic governance arrangements, which would determine important considerations such as who would have decision-making power, how decisions would be made, or how new initiatives would mesh with the existing architecture.

The paper concludes by calling for greater consideration of the political and technical processes required to implement change, such as the minimum number of countries or other actors required to effect significant systemic change. Although the scope of this paper restricts specific proposal recommendations, the analysis facilitates further review of the global health system. The objective of this review is to build stronger institutions for financing global health, which are more equitable.

De Cock K, Simone P, Davison V, Slutsker M. The New Global Health. Emerging Infectious Diseases, 2013; 19 (8)
http://wwwnc.cdc.gov/eid/article/19/8/13-0121_article

The authors of this paper call for better coordination between multiple organisations. Global health can be divided into three overlapping themes for action and prioritisation. These are development, security, and public health. Demographic change, socioeconomic development, and urbanisation will impact upon all three themes. It must be recognised that the world has changed, and the global approach to health must change too. While infectious disease will have an impact on global health, it is no longer the major cause of global illness and death. Traditional indicators used to assess public health (such as maternal and infant mortality rates) may no longer be suitable to describe societal health status. A different approach is

needed, including vital registration and disease specific reporting. Noncommunicable diseases, injuries, and mental health need to be the focus in the future. Health equity, access, and coverage need to be prioritised. Broader engagement is needed by health organisations and all countries beyond the current MDGs time frame.

House of Lords Intergovernmental Organisations Committee - First Report, 2008. Chapter 3: international health: the institutional labyrinth
http://www.publications.parliament.uk/pa/ld200708/ldselect/ldintergov/143/14302.htm

This chapter reviews the interaction of the various actors on the international health stage, particularly those concerned with infectious disease control. It divides the main organisations involved in controlling the global spread of infectious diseases in to five main groups:

1. Intergovernmental Organisations with either wholly or partially health-related mandates, including the World Health Organization, the World Bank, UNAIDS and UNICEF.
2. National Governmental Organisations operating internationally in the field of infectious disease control, including the UK Department for International Development, the US Centers for Disease Control and the US Presidential Emergency Programme for AIDS Relief (PEPFAR).
3. Non-Governmental Organisations, such as Médecins Sans Frontières, the Malaria Consortium and the International HIV/AIDS Alliance.
4. Public-Private Partnerships, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID and the Global Alliance for Vaccines and Immunisation (GAVI).
5. Private Foundations, much the largest of which is the Bill and Melinda Gates Foundation.

The fragmentation of effort may results in significant problems, including multiplication of overhead costs. Individual organisations tend to focus on specific diseases, rather than addressing the wider issue of infectious disease control. Each organisation may have their own structure and process, which may lead to inefficiency. Roles must be clarified and a vision agreed upon. A major problem is the lack of collaboration due to organisations competing for funding. Institutions like the Global Fund which channel funds across more than one disease area has helped to reduce fragmentation of effort.

The WHO is regarded as occupying a central position in combating the global spread of infectious diseases. However, the world had changed since it was created and that these changes were now affecting the WHO itself. Although the WHO sits at the centre of global health policy-making, it has been overshadowed in resource terms by newly-emerging funding organisations, whose budgets are significantly greater than the WHO's own core budget. Highly infectious diseases (such as SARS and avian flu) are another important driver for change for the WHO. Pandemics themselves are not new, but in the globalised world, unless highly infectious diseases are quickly brought under control in the country of origin, they can spread rapidly throughout the world and create grave global health problems.

The current architecture is reported to be crowded and poorly coordinated. It is recommended that in the medium term a large number of existing initiatives should be rationalised through mergers. Gillian Merron, [former] Parliamentary Under-Secretary of State at DFID, described it in oral evidence as "a situation that we know needs to be remedied". "There is", she said, "very much scope to improve the effectiveness and coherence of intergovernmental organisations that are working on health and communicable diseases".

United Nations Development Programme (UNDP), Human Development Report 2014 - Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience. UNDP, 2014, New York, USA.

http://hdr.undp.org/en/2014-report

This report focuses on vulnerability and proposes ways to strengthen resilience. It recognises that people are vulnerable to crises with potentially destructive consequences, no matter how effective policies are in reducing inherent vulnerabilities. Building capacities for disaster preparedness and recovery, which enable communities to be more resilient to shocks is vital. Institutions, structures and norms can work to enhance or diminish resilience. State policies and community support networks can empower people to overcome threats when and where they may arise, whereas horizontal inequality may diminish the coping capabilities of particular groups. At the global level, transborder risks require collective action. This report calls for global commitments and better international governance.

There currently is a mismatch between governance mechanisms and the vulnerability and complexity of global processes. Many international institutions and structures are in need of reform. New regimes, such as those for global intellectual property rights, often benefit elites disproportionately. Governance systems may result in new vulnerabilities, while entrenching old ones. The problems of the failing global governance architecture stem from deep asymmetries of power, voice and influence. The agendas of the least developed countries are underrepresented. It is essential to ensure equitable participation of developing countries in global governance so that the needs of more-vulnerable countries are not marginalised. Participation must also be extended to include perspectives from the private sector and civil society to ensure support for global collective action among states. Governance will be most effective if decisions are made in representative institutions, not in ad hoc groupings of countries or in selective meetings which lack transparency. Greater coordination and cooperation among global governance institutions in different issue areas can reduce spillovers and better align goals.

To progress, the authors argue that there is a need to reach some degree of consensus about the underlying moral and ethical principles that define global health cooperation. Another challenge is the need to agree on leadership and authority in global health governance. The potential role of nonstate actors within the global health governance system needs to be defined more clearly. Relationships, patterns of influence and agreed roles among state and nonstate actors within the system are still emerging. Also, the willingness of states to ‘pool’ their sovereignty and act collectively is a significant hurdle. The absence of a single institution, with the authority and capacity to act decisively, to address health issues of global concern is another. The need to generate sufficient resources for global health cooperation and distribute them appropriately according to agreed priorities will also be a challenge. Global health initiatives may lack teeth because of the lack of effective enforcement mechanisms. As the globalization of health continues, health governance will have to become broader in participation and scope

Loughlin K, Berridge V. Global Health Governance: Historical Dimensions of Global Governance. Geneva: World Health Organization and London School of Hygiene and Tropical Medicine, 2002.
http://cgch.lshtm.ac.uk/globalhealthgovernancepaper2.pdf

This paper highlights the potential of historical analysis to clarify and strengthen the concepts and definition of global health governance. It outlines key themes and issues mobilised in debates about global health governance. It demonstrates how historical analysis challenges ideas of the ‘newness’ of some of these developments. It also presents an overview of historical international health governance and argues that assumptions about contemporary patterns and relationships need to be tested against this longer history.

Ruger J. Global Health Governance as Shared Health Governance. Journal of Epidemiology and Community Health, 2012; 66 (7)
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1973693

Apart from a few global successes, the current regime of global health governance can be understood as transnational and national actors pursuing their own interests under a rational actor model of international cooperation. In its current state, it fails to provide sufficient justification for an obligation to assist in meeting the health needs of others. A stronger commitment to all people being healthy is needed. A shared health governance framework based on shared ethical commitments, must be introduced, allowing global health actors, including states, to work together to correct and avert global health injustices.

Ruger J. Governing health. Harvard Law Review Forum, 2008; 121
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1124542

This paper is a response to an article by Volokh, which argues for a constitutional right to medical self-defence for two purposes: first, to allow terminally ill patients to purchase, at their own expense, drugs that have not completed the Food and Drug Administration's (FDA) approval process and, second, to allow all individuals access to transplanted organs for which there are current bans on payment. His claim, in essence, is that we should allow markets for experimental drugs and human organs and that prohibition of such markets is unconstitutional. He grounds this constitutional right to medical self-defence in the common law justification of lethal self-defence, and sees this principle as analogously justifying abortion jurisprudence and therefore a relevant justificatory claim for other domains of health care.

This response presents an alternative theoretical approach to the question of rights to health and health care, arguing that a right to health care need not, indeed cannot, be framed in an absolute libertarian framework of wholly individualistic rights against the state. Instead, a right to health is grounded in the more positive conceptualization of freedom - human flourishing - arguing for treating the right to health as an ethical demand for equity in health. Unlike the legalistic, yet theoretically ungrounded, guarantee of a right to medical self-defence, a right to health so conceived purports that the regulation of self and society necessitate not just justiciable and enforceable legal rights or instruments, but also individuals and a collective with internalised public moral norms that inform the choices they make for themselves and their society to ensure capabilities to be healthy for all people, including the terminally ill.

It argues that the state is obligated to generate public goods through scientific evaluation that are required for consumption by individual agents, as a critical component of a framework to effectuate a right to health. The FDA and other state supported entities have not only a legislative claim, but also a moral duty to draw on the collective scientific resources a society has to offer in providing the rigorous and scientifically grounded evidence base needed to give all individuals the opportunity to be healthy. Efforts to undermine and delegitimise this role rob all individuals (present and future) of the necessary conditions for their optimal health functioning and health agency.

Ruger J, Yach D. The Global Role of the World Health Organization. Global Health Governance, 2009; 2 (2)
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3981564/

The authors of this paper argue that the current global health landscape requires effective global action to respond to challenges posed by globalisation of trade, travel, information, human rights, ideas, and disease. This plural global health era comprises of a number of key actors, and requires more coordination of effort, priorities and investments. The WHO plays an essential role in the global governance of health and disease; due to its core global functions of establishing, monitoring and enforcing international norms and standards, and coordinating multiple actors toward common goals. WHO leadership is required, as is effective implementation of WHO's core global functions to ensure better effectiveness of all

health actors. Narrowing activities and budget reallocations from core global functions may hamper progress.

Fidler D. Global Health Governance: Overview of the Role of International Law in Protecting and Promoting Global Public Health. Geneva: WHO and London School of Hygiene and Tropical Medicine, 2002.
http://apps.who.int/iris/handle/10665/68936

This paper explains the role of international law in protecting and promoting global public health. The author suggests that international law is necessary but not sufficient to create effective global health governance. The paper looks at: the theoretical and practical need; the structure and dynamics; how deeply imbedded public health is; the different kinds of global governance mechanisms in international law and the limitations of international law.

Lee K. International Organization and Health/Disease. The International Studies Compendium, 2009; 07 (228)
http://www.isacompendium.com/public/tocnode?id=g9781444336597_yr2013_chunk_g978144433659711_ss1-38

This paper starts with a brief review of the history of global health architecture, including the formation of the establishment of the World Health Organization (WHO) as the UN agency specialising in health. It goes on to describe some of the challenges that exist for the current health architecture and describes the literature which has emerged on the numerous and diverse institutional actors concerned with global health. The shift from international to global health has resulted in collective action between parties to achieve functional needs. The paper concludes with a look at the possible future direction of research on this theme, with findings from research from outside the formal disciplinary boundaries of international relations being expected to make a significant contribution. This literature, primarily from the perspective of public health, will tend to focus on improving the contemporary institutional mechanisms for addressing collective health problems.

Fan V, Glassman A. Value for Money in Health: a framework for global health funding agencies. Center for Global Development. First draft 2012. Forthcoming.

International commitments are increasingly ambitious and aid resources are become increasingly constrained. Global health funding agencies must improve the efficiency and impact of their investments. This framework provides targeted recommendations for global health funding agencies to increase impact per dollar spent and create conditions for sustainable investments in health. It focuses primarily on how global health funding agencies and donors can enhance the leverage of their own funding and payments to improve health in recipient countries. It offers a working framework for global health funding agencies who seek to reduce costs while increasing health impact per dollar spent.

3. Key relevant literature on health architecture post 2015

Hoffman S. Røttingen J-A. Split WHO in two: strengthening political decision-making and securing independent scientific advice. Public Health, 2014;128 (2)
http://www.ncbi.nlm.nih.gov/pubmed/24434035

The WHO has failed to fulfil its original mission of simultaneously serving as the world's pre-eminent public health authority and intergovernmental platform for global health negotiations. It is undermined by an institutional design that mixes technical and political mandates. The result is mediocrity on both fronts. The authors suggest the WHO should be split in two, separating its technical and political stewardship functions into separate entities, with

collaboration in areas of overlap. Change could be implemented by revising WHO's constitution, or through simpler mechanisms. Structural governance reforms would need to be accompanied by complementary changes in culture that support strengthened political decision-making and scientific independence. States' inability to act on WHO's institutional design challenges will only lead them and non-state actors to continue the trend of the last 15 years of bypassing the WHO through the creation of new entities. More must be demanded from the WHO and the ambitions of member states must be included in the reform process.

Buse K, Hawkes S. Health post-2015: evidence and power. The Lancet, 2014; 383 (9918)
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61945-5/fulltext

This comment piece argues that the international community faces a historic opportunity to ensure that health priorities truly reflect the health needs of current and future generations. To succeed attention must be paid to the voices of those affected, to evidence-driven priorities, and to the politics of change. It is clear that addressing the global burden of disease, and promoting healthy lives, cannot be a function of the health system alone. Cross-sectoral action will be required and can only succeed if they are supported by a range of global functions and global public goods.

Hoffman S, Røttingen J-A. Be sparing with international laws. Nature, 2012; 483 (27)
http://www.nature.com/nature/journal/v483/n7389/full/483275e.html

In a correspondence to address Sridhar's proposal for a Framework Convention on Alcohol Control, the authors argue that the standards set by international laws are largely dictated by powerful states and their expectations. Poorer states are obliged to implement these global policies ahead of local priorities. Litigation by foreign non-governmental organisations (NGOs) can also get in the way of national policy-making, particularly as most NGOs are led from the West. Sridhar is not the only person calling for new international health laws. The authors argue that more evidence is needed to show that international laws achieve results commensurate with the cost of drafting, ratifying and implementing them. A clear criteria, possibly set by a commission on global health law, would need to be fulfilled before the WHO invokes its law-making authority. Ill-justified international health laws that dictate poor countries' policies and priorities from afar could prevent serious consideration of initiatives better suited to legal instruments.

Hoffman S, Røttingen J-A. Assessing implementation mechanisms for an international agreement on research and development for health products. Bulletin of the World Health Organization, 2012; 90
http://www.who.int/bulletin/volumes/90/11/12-109827/en/

WHO member states are debating an international agreement to improve the financing and coordination of R&D for health products that meet the needs of developing countries. This paper calls on member states to reflect on the full range of implementation mechanisms in addition to legal and political agreement. These mechanisms include:

- States to making commitments, administer activities, manage financial contributions, making subsequent decisions, monitoring each other's performance and promoting compliance.
- States making binding or non-binding commitments through conventions, contracts, declarations or institutional reforms.
- States administering activities to implement their agreements through international organisations, sub-agencies, joint ventures or self-organising processes.
- Finances being managed through specialised multilateral funds, financial institutions, membership organisations or coordinated self-management.

- Decisions being made through unanimity, consensus, equal voting, modified voting or delegation.
- Oversight can be provided by peer review, expert review, self-reports or civil society.

The authors call on states to select their preferred options across categories of implementation mechanisms. The most effective combinations of mechanisms for supporting an international agreement (or set of agreements) must be selected to achieve collective aspirations in a way and at a cost that are both sustainable and acceptable to those involved. The years of experience of these different mechanisms in health and its related sectors could prove useful to member states in the decision making process.

Buse K, Sidibé. AIDS governance: best practices for a post-2015 world. The Lancet, 2013; 381 (9884)
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2961413-0/fulltext?_eventId=login

This comment reports on the High-Level Panel post-2015 report. It states that the AIDS response is an example of a successful public health initiative. Governance has been the key to this success. In forging a transformative governance architecture of the future, the principles that are fundamental to the success of the AIDS response must remain at the heart of the new agenda. This includes the centrality of justice, human rights, and gender equality. Discrimination, stigma, and criminalisation of people living with, and at increased risk of, HIV remain the main barriers to services. Human rights must be promoted as both an entitlement and engine of development. Governance must be inclusive and involve participation from people and communities most affected. The post-2015 agenda must be integrated. The new agenda should build better linkages throughout the new development architecture. Action should be data-driven, evidence-informed, and results-oriented. Transforming global governance for health will require continued investment—but it will be an investment in results.

Hoffman S, Røttingen J-A. Global health governance after 2015. The Lancet, 2013; 382 (9897)
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2961966-2/fulltext

This comment responds to the suggestion by Sidibé and Buse that global health architecture needs no more than three agencies: one to handle financing; one to set norms and standards; and one for advocacy and accountability. The authors argue this is incorrect as the global health system involves more than the sum of these three processes. Core functions include the production of global public goods, management of externalities across countries, mobilisation of global solidarity, and stewardship. Technical work, monitoring, multilateral negotiations, and lending must also be supported by the architecture. Even with reforms, the authors argue that the Global Fund, WHO, and UNAIDS alone would struggle to deliver on these functions. In addition it is argued that accountability is everybody's business. A single agency cannot be fully accountable for everyone. Accountability needs to be mainstreamed and new models of multidirectional accountability developed to ensure everyone holds everyone else responsible for resources, rhetoric, rights, and results. Advocacy is similarly best performed by many actors, including civil society organisations and their constituencies. Consolidating authority among too few hegemons and assigning accountability and advocacy to one agency is not advised. It is agreed that simplification and greater efficiencies are needed, but it is contended that a monopoly of power will not work in a complex multipolar world.

Kickbusch I, Brindley C. Health in the Post-2015 Development Agenda. WHO, 2013
http://apps.who.int/iris/handle/10665/85535

The positioning of health is an urgent challenge as discussions of the post-2015 agenda rapidly advance. The next steps imply the need to ensure recognition of the key governance challenges encountered in health. In particular, the human rights and equity challenge in the governance of the health system and what we have come to call governance for health in other sectors. Within the health arena, universal health coverage (UHC) and social determinants of health have come to stand for these two dimensions of governance and are central to any goals that might be defined for health in the post-2015 agenda. The view that development issues are interconnected is prominent in all thematic reports. There is also a clear awareness that development issues have a strong political dimension and are not merely technical problems.

WHO should brief member states on the post-MDG processes, the importance of positioning health prominently in the post-2015 development framework, and suggested priorities and approaches for post-MDG negotiations. This could be done by convening meetings of representatives from member states involved in the negotiations to discuss priorities and approaches for health. It is important to note that many of the chief negotiators will come from ministries of foreign affairs or agencies for development. WHO will need to explain preferred health terminology and promote common use of language across sectors. As appropriate other health stakeholders, including NGOs and the private sector should be invited.

D'Ambruoso L. Global health post-2015: the case for universal health equity. Global Health Action, 2013; 6: 10
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3617874/

Discussions on the goals, topics, priorities and M&E that will come in the post-2015 era are gaining momentum. Over a decade of development programming offers a unique opportunity to reflect on its structure, function and purpose in a contemporary global context. This paper examines the topic from an analytical health perspective and identifies universal health equity as an operational and analytical priority to encourage attention to the root causes of unnecessary and unfair illness and disease from the perspectives of those for whom the issues have most direct relevance.

United Nations. A New Global Partnership: Eradicate Poverty and Transform Economies through Sustainable Development. United Nations, 2013; New York, USA
http://report.post2015hlp.org/

A group of 27 eminent people from around the world came together to advise the United Nations Secretary-General on his recommended development agenda to succeed the Millennium Development Goals. Their report sets out a universal agenda to eradicate extreme poverty by 2030, and deliver on the promise of sustainable development. The report calls upon the world to rally around a new Global Partnership that offers hope and a role to every person in the world. The authors argue that the post-2015 agenda is a universal agenda that needs to be driven by five transformative shifts:

1. Leave no one behind.
2. Put sustainable development at the core.
3. Transform economies for jobs and inclusive growth.
4. Build peace and effective, open and accountable institutions for all.
5. Forge a new global partnership.

The Panel argues that the shape of the post-2015 development agenda cannot be communicated effectively without offering an example of how goals might be framed. The following illustrative goals are presented for health:

- End preventable infant and under-5 deaths.

- Increase by x% the proportion of children, adolescents, at-risk adults and older people that are fully vaccinated.
- Decrease the maternal mortality ratio to no more than x per 100,000.
- Ensure universal sexual and reproductive health and rights.
- Reduce the burden of disease from HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and priority non-communicable diseases.

Ooms G, Sridhar D, Jahn A. Global health governance after 2015. The Lancet, 2013; 382
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2961964-9/fulltext

The report of the High-Level Panel appointed by the UN Secretary General to advise on the global development framework [detailed above] proposed targets concerned with specific health challenges, interventions, and diseases, which might further deepen the current fragmentation of health delivery platforms, already seen by many as an undesired side-effect of the current MDGs. It did not include universal health coverage as a goal or target, despite its emergence as a unifying theme among the global health community. Proposed targets may lead to different players following different agendas, and thus they will be pitted against each other. Universal health coverage anchored in the right to health would allow united advocacy. The authors use this correspondence to propose the realisation of the right to health for everyone as a singular health goal. The two targets of comprehensive universal health coverage anchored in the right to health and a healthy social and natural environment for all are also proposed.

Health in the post-2015 agenda. Report of the Global Thematic Consultation on health, 2013
http://www.worldwewant2015.org/file/337378/download/366802

Between September 2012 and March 2013 a Global Thematic Consultation on Health in the Post-2015 Development Agenda received inputs from people and organisations around the world on how best to ensure the health of future generations. This report is a summary of the findings from the full consultative process. A rigorous framework is needed for the post-2015 agenda, to articulate how sustainable development differs from (and is preferable to) existing development models. Also as health and development are inextricably linked, greater synergy must be realised between health and other sectors by framing new goals in such a way that their attainment requires policy coherence and shared solutions across multiple sectors. The guiding principles for the new development agenda should include human rights, equity, gender equality, accountability, and sustainability. The most disadvantaged, marginalised, stigmatised, and hard-to-reach populations in all countries should be prioritised.

The report finds that the post-2015 health agenda should do the following:

- Include specific health-related targets as part of other development sector goals.
- Take a holistic, life-course approach to people's health with an emphasis on health promotion and disease prevention.
- Accelerate progress where MDG targets have not been achieved and set more ambitious targets for the period to come.
- Address the growing burden of NCDs, mental illness, and other emerging health challenges.

Evans D, Hsu J & Boerma T. Universal health coverage and universal access. Bulletin of the World Health Organization. 2013; 91
http://www.who.int/bulletin/volumes/91/8/13-125450/en/

Universal health coverage is a possible goal for health in the post-2015 development agenda. To achieve it, people must have access to good health services without fear of financial hardship. It cannot be attained unless both health services and financial risk protection systems are accessible, affordable and acceptable. However universal access is not sufficient. Coverage builds on access by ensuring actual receipt of services. Universal health coverage and universal access to health services complement each other. Without universal access, universal health coverage becomes an unreachable goal.

Vega J. Universal health coverage: the post-2015 development agenda. The Lancet, 2013; 381
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2960062-8/fulltext?_eventId=login

Universal health coverage is becoming a key global health objective. To achieve it, health must deliver and evaluate access to coverage for needed health services (prevention and treatment) and access to coverage with financial risk protection. The ultimate goal is for everyone to have access to health at an affordable cost. By focusing the post-2015 health agenda on universal health coverage, the international community has an opportunity to endorse a country-driven agenda, as well as build and improve upon what the MDGs have achieved so far.

Victora C, Saracci R, Olsen J. Universal health coverage and the post-2015 agenda. The Lancet, 2013; 381 (9868)
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2960581-4/fulltext

In the post 2015 health agenda, universal health coverage should be a central health goal, but it should not be the only health goal. The following points must be considered:

- A health goal should be represented by a meaningful health status outcome.
- Such a goal should be measurable across countries.
- Health care is only one of a multitude of factors affecting health.

Life expectancy is an easily understood concept, which accounts for the multiple determinants of health and disease. It is proposed that life expectancy, assessed at different ages - and, where feasible, expanded into healthy life expectancy - should become the overarching goal.

Sridhar D, Brolan C, Durrani S, Edge J, Gostin L, et al. Recent Shifts in Global Governance: Implications for the Response to Non-communicable Diseases. PLoS Med, 2013; 10 (7)
http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001487

There are three major trends in global governance: 1) the rise of emerging economies, 2) the increase in multi-bi financing, and 3) institutional proliferation. These have implications for whether Non-communicable Diseases (NCDs) will be included in the post-2015 Sustainable Development Goals (SDGs) agenda. While emerging economies are influential in global governance, it is not clear that the interests of poorer countries - or even health - will be advanced. If NCDs are included in the new health goals, it likely will be via the broad umbrella of healthy life expectancy, or the sector-specific target of universal health coverage or access. Universal health coverage or healthy life expectancy as currently conceived are unlikely to adequately incorporate NCDs that require alternative health system mechanisms and clear governmental intervention.

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5. Additional information

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