Policy Series No. 29

Global actors in health policy

In 1948, the World Health Organisation (WHO) was established as the agency for directing and coordinating authority on international health work, particularly in setting norms and standards and policies in public health , establishing and maintaining effective collaboration with the United Nations, specialised agencies, governmental health administrations, professional groups and such organisations as may be deemed appropriate, furnishing appropriate technical assistance in emergencies, necessary upon request or acceptance of governments (WHO Constitution Chapter II Art 2) By 2011 many new institutions exist in global health, with different governance mechanisms and funding, powers and mandates. This brief explores the range and influence of global health actors and the implications for health diplomacy within east and southern Africa.

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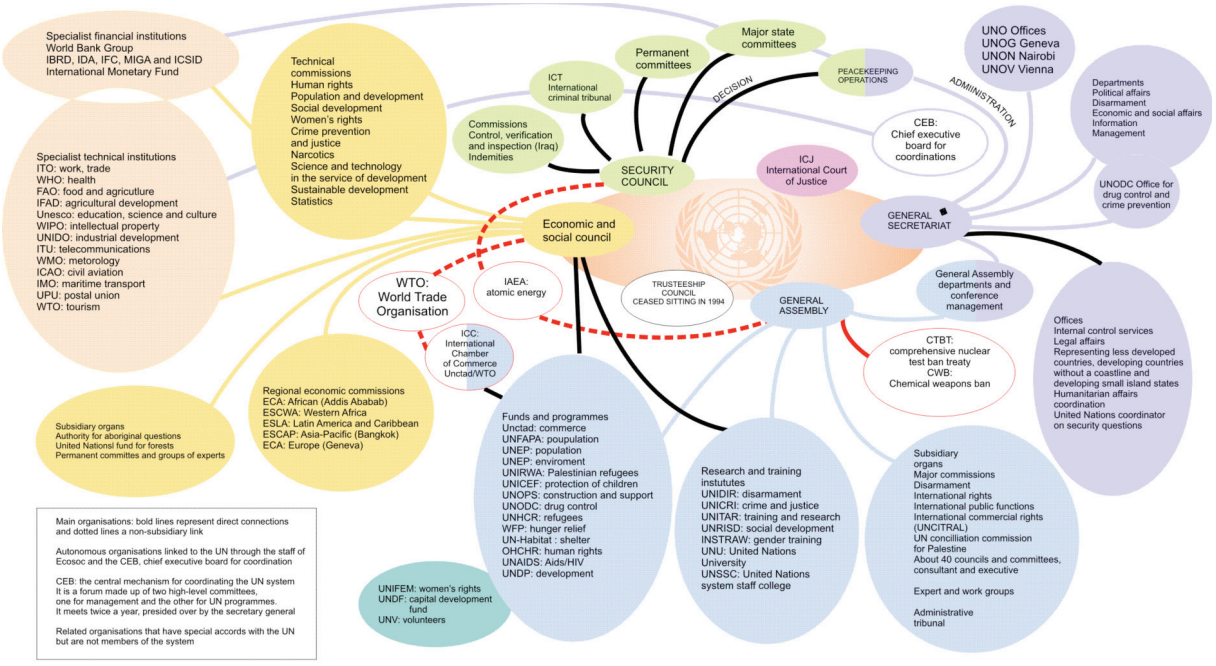
East Central and Southern Africa Health Community

The changing UN architecture in health

The nature of global health has changed dramatically in the past two decades, bringing in many actors to expand responses to global health needs, including service delivery, prevention, and research and development. Besides governmental activities, the involvement in health of non governmental organizations, non-state providers of health, industry, faith-based organizations and civil society has increased. Few successful health initiatives now depend on a single organization.

The UN system itself has a number of institutions that have mandates that affect health and policy platforms for health. The figure below shows the complex institutional architecture of the United Nations.



Source: Rekacewicz P Le Monde Diplomatique, September 2005

Beyond the UN Assembly, there are a number of specialized agencies, Funds and Programs, with different governance mechanisms. The 'Funds' (eg UNICEF) largely based in New York have 'stakeholder boards', while the intergovernmental agencies (eg WHO, ILO) largely based in Geneva have member state governing bodies. The Funds include organisations such as those within the UN social agencies. United Nations Children's Fund (UNICEF) works on health issues of children including procurement of medicines. The United Nations Population Fund (UNFPA) supports countries on population policies

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and reproductive choice and health. The Joint United Nations Programme on HIV/AIDS (UNAIDS) has a mandate to coordinate and leverage the global response to HIV and AIDS.

UN technical agencies such as the World Intellectual Property Organization (WIPO) deal with developing an international intellectual property (IP) system which rewards creativity, stimulates innovation and contributes to economic development while safeguarding the public interest. WIPO also deals with the development of technical standards.

This increasingly complex architecture has led to concern about the lack of effective co-ordination across UN policies and the inadequate machinery for monitoring implementation of the hundreds of multilateral treaties, which although sectoral in character, also impinge on global public health. The 'Helsinki Process' exploring the global policy environment raised 'three deficits that need to be overcome in global governance arrangements and that affect African negotiations in global diplomacy:

- 'democracy" deficits as power is concentrated in the hands of a few governments
- "coherence" deficits between Ministries within governments and between international agencies leading to conflicting obligations and policy dissonance, and
- "compliance" deficits as international institutions are failing to implement decisions they make (Foster 2005).

The influence of economic institutions

There is also concern over the asymmetrical power relationships between the international finance institutions (IFIs) and national governments (Bandula 2011). The United Nations Development programme (UNDP), UN social agencies, southern governments and civil society have raised concern about the manner in which global public institutions set the rules on globalisation. In contrast to the binding and enforceable agreements of the World Trade Organisation (WTO), the standards set by the WHO and many other UN specialized agencies are not enforceable. The WTO is best known in the health sector for the Trade Related Aspects of Intellectual Property Rights (TRIPs) that deals with protection of intellectual property, which has affected access to medicines. WTO agreements not only cover trade in goods, but also trade in services and standards that affect health shown in Table 1.

The IMF and World Bank were established to promote international monetary cooperation and exchange rate stability and to assist with poverty reduction. However, both have in the 1980s instituted prescriptive economic conditions for receiving financial support or loans and Structural Adjustment Programmes that have influenced a much wider spectrum of policy, including in health. For example the structural adjustment programmes have led to falling public budgets for health, a growth in private and voluntary provision and increased cost recovery for health care, with negative consequences for health (Breman and Shelton 2001).

Table 1: Health issues and relevant World Trade Organisation agreements

WTO rules	SPS	TBT	TRIPS	GATS
Health Issues	■	■	■	■
Infectious disease control	■	■		
Food safety	■			
Tobacco control		■	■	■
Environment	■	■		
Access to drugs			■	
Health Services				■
Food security	■			
Biotechnology	■	■	■	
Information technology			■	
Traditional knowledge			■	

Key: SPS = Sanitary and Phytosanitary Measures TBT = Technical Barriers to Trade TRIPS = Trade Related Intellectual Property Rights GATS = General Agreement on Trade in Services
Source: Drager, 2004.

The influence of private global foundations and other international organisations

Private foundations have become significantly more influential institutions in global health, directly and sometimes in partnership with the WHO. According to WHO, the number of global health partnerships has increased steadily over the past decade and more than 100 private global foundations now exist. The term "partnerships" as used by WHO encompasses a large diversity of organizational structures, relationships and collaborative arrangements among participating stakeholders (EB122/19). Global foundations and alliances that have private participation include, for example:

1. **Mutilateral and Private Sector Initiatives** and Joint Ventures, such as the Multilateral Initiative on Malaria; the PATH's Malaria Vaccine Initiative (MVI); the World Bank and HIV/AIDS; World Bank's Malaria Booster Program
2. **Partnerships,** such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Global Network for Neglected Tropical Diseases, the Roll Back Malaria immunisation Partnership, the Stop TB Partnership, and the TB Alliance, the GAVI Alliance (on) and Global Alliance for TB Drug Development, and UNITAID
3. **Private Foundations,** such as the Acordia Global Health Foundation, Aeras Global TB Vaccine Foundation, Bill & Melinda Gates Foundation, William J. Clinton Foundation.
4. **Civil society**. In line with developments elsewhere within the UN system, civil society role in global health has continued to increase, particularly in shaping and influencing ideas within the system.

This raises the issue of where control and leadership of the vision, mandates and functioning of the 'partnerships' lie. Tax-exempt private foundations and for-profit corporations are becoming more influential in global health and public health foundations have associations with private food and pharmaceutical corporations. Personnel move between food and drug industries and public health foundations. Foundation board members and decision-makers also sit on the boards of some for-profit corporations benefitting from their grants (Stuckler et al 2011). The Bill & Melinda Gates Foundation's Endowment Trust had US$29.6 billion assets under its management with significant shares in food corporates like McDonald's, Coca Cola and in pharmaceutical corporates like GlaxoSmithKline. Endowment investments in pharmaceutical and food companies are also found among the Ford, Rockefeller, W. K. Kellogg Foundation, and Robert Wood Johnson Foundations (Stuckler at al 2011). A review of five foundations by Stuckler et al (2011) found that while private foundations adopt standard disclosure protocols for employees to mitigate potential conflicts of interest, these do not always apply to the overall endowment investments of foundations or to board membership appointments. The authors suggested that the relationships between tax-exempt foundations and for-profit corporations may lead to conflicts of interests between global health programs and their financing.

Implications for health diplomacy and WHO

As private foundations have become increasingly influential in global health in the 2000s, the spectrum of actors raise new challenges to negotiating public policy interests in health. These include concerns about transparency and conflicts of interest in health policy setting processes, particularly given that some of the private actors in partnerships and the alliances have funds that exceed the contributions to UN organisations of member states. The Gates Foundation has for example become the second largest donor to the WHO after the United States, at a time when the WHO, was facing (in 2010) a financial deficit of US$300 million.

Countries across the income spectrum have raised questions about the multiplicity of global partnerships and alliances. The contributions of private foundations, while significant, are often limited to very specific areas of focus and interest, and depend on an infrastructure funded by the contributions of states, some with much lower per capita resources. Formal partnerships present specific challenges for WHO, particularly when it accepts to serve as the host organization of the programmes the private foundations would be supporting. Countries have for example noted that such partnerships raise a demand for clarity on what their purpose and mandate are in relation to the purpose and mandate of WHO, the ability within WHO to support the partnership, the consistency with WHO's rules and regulations, the interaction with the Programme budget, and clarity of how the partnerships work with and/or through WHO's regional and country offices (EB122/19 20 December 2007).

Implications for east and southern Africa

Within these wider debates on the global health architecture, the current environment raises a number of issues for east and southern African (ESA) countries. ESA countries have a challenge to ensure effective and fair representation in the decision making mechanisms of public and multilateral institutions and partnerships, such as, for example, the GFATM. Such concern led the Regional Health Ministers in the East Central and Southern Africa (ECSA) Health community in 2010 to resolve to support the Global Fund Constituency Board Member to effectively represent all Member Countries. This would need to be operationalised to ensure that the interests of the ECSA countries are represented and safe guarded in the decisions by the Board of the Global Fund.

The challenge of representation of ESA interests in health would also appear to demand

i. Co-ordination in negotiations across different global multilateral actors that influence health issues, to avoid policy incoherence or policy conflict and to draw synergies across the different areas;
ii. Full disclosure of actual or potential conflicts of interest in any forums where public health decisions are under negotiation. This means being clear about the governance structures and interests of those 'around the table', including disclosing corporate affiliations (directorships, advisory panels, funding receipt) and investment holdings of individuals and institutions; and
iii. A mechanism for tracking and building accountability for the global resources dedicated to public health, particularly given the high concentration of global health needs within the region.

The proliferation of actors at the global level and national level has stretched the capacity of the Region to meaningfully participate in the discourse on global public health. It is crucial that the African Region draws strength from its numbers, and strengthen its collective capacities, mechanisms and dialogue (within the WHO Regional Committee for the Africa Region; the regional bodies and the Africa Group in Geneva and during the World Health Assembly meetings) given the scope and breadth of the global health agenda.

While new south-south alliances and interactions are emerging in the engagement with this diversity of global health actors, this does not detract from the need to safeguard the leadership of WHO in global health. According to one Geneva based African diplomat it has equally become a matter of global health diplomacy to safeguard the WHO, in line with its constitutional mandate, and in consultation with other stakeholders, coordinate global efforts in health. This includes ensuring that the norms, standards and policy guidance of the organisation are rooted in its constitutional norms and are evidence based.

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iii. WTO http://www.wto.org; World Bank http://www.wordbank.org and IMF http://www.imf.org

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