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Centre on Global Health Security: Workshop Summary

Moving Towards Universal Coverage: Identifying Sustainable Methods for Improving Global Health Security and Access to Healthcare

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Introduction

In the first half of 2012 the Chatham House Centre on Global Health Security established two high-level Working Groups led by internationally prominent chairs and comprising some of the leading actors in the field of global health. The first meeting of the Working Groups was held at Chatham House on 8 and 9 October 2012.

The Working Groups, which aim to identify sustainable methods for improving global health security and access to healthcare, and to influence international and national policy-makers, emerged from a major international conference held at Chatham House in December 2011 to mark the tenth anniversary of the publication of the report by the World Health Organization's (WHO) Commission on Macroeconomics and Health (CMH). The 2011 conference used the commission's original recommendations as a vehicle for considering what countries and donors need to do in the changed economic circumstances of today to scale up health services and provide access for all to essential health interventions.

Working Group 1 (WG1) on 'WHO and the International System' is chaired by Dr Viroj Tangcharoensathien, Ministry of Public Health, Thailand.

Working Group 2 (WG2) on 'Commitments to Sustainable Financing: Need for a New Model?' is chaired by Professor John-Arne Røttingen of Oslo and Harvard Universities.

The full list of members of the groups is at the end of this paper.

Two more meetings are scheduled in April and October 2013, with final reports due at the end of 2013.

At this first meeting of the Working Groups the objectives were to address the following general questions:

- What should be the scope and the focus of the working groups?
- What can the Chatham House process contribute to policy formation? How can it add value?
- What products can the two Working Groups deliver?
- How can the recommendations influence policy decisions at national and international levels? What channels can be used to influence official processes?
- How can the Working Groups influence the post-2015 development agenda just as the CMH influenced the original Millennium Development Goals (MDGs)?

The meeting began and ended with joint discussions of the groups to consider their shared or overlapping agendas. The groups initiated their discussions by considering four background papers commissioned by Chatham House. These were:

For WG1,

- 'The Role of the World Health Organization in the International System' by Charles Clift
- 'Innovation in Global Health 1998–2008' by Jon Lidén

For WG2,

- 'Raising and Spending Domestic Money for Health' by Riku Elovainio and David Evans
- 'Development Assistance for Health: Critiques and Proposals for Change' by Suerie Moon and Oluwatosin Omole.

Chatham House will publish these papers shortly following revisions to take account of comments from the working groups.

The meeting was held under the Chatham House Rule. Participants are 'free to use the information received, but neither the identity nor the affiliation of the speakers may be revealed'.

Working Group 1

Working Group 1 had a broad-ranging discussion drawing on the issues raised by the background papers. These included extensive analysis of several topics concerning the effectiveness of the WHO's work, the way it was governed and financed, including its unique regional structure, and the progress of the current internal reform programme. A central theme was what the multiplication of other global health actors in recent years (new public-private partnerships and funding institutions) implied for the WHO's role. Some noted that critical health discussions in the UN appeared to be moving from Geneva to New York, or indeed elsewhere. There was a feeling that the WHO could become marginalized.

Particular issues discussed included:

The WHO's overall role

- In the current global health context, is there a need for a UN specialized health agency? If so, are the functions listed in Article 2 of the WHO's constitution relevant to today's global health landscape? Are there functions that the WHO should not be undertaking or new functions that it should? In particular, is it necessary to redefine its principal function as the 'directing and coordinating authority on international health work'? What are the things that 'only the WHO can do'? What do other global health bodies need from the WHO? What do countries need from the WHO? What do other stakeholders in industry and civil society need from the WHO? Where does the WHO fit in the development context?

- How could the WHO as an intergovernmental body effectively consult non-governmental actors in the policy-making process?

- Apart from the WHO's role in the 'traditional' international health arena, how could it effectively address the importance of social determinants of health and the impact of sustainable development issues on health? What does that mean for the composition of staffing and skill mix of the WHO and the way it operates?

- Should the WHO be a bigger player in the fight against non-communicable diseases (NCDs), obesity and related lifestyle issues, including confronting industry's roles in contributing to disease, as was done in the case of tobacco?

- What is the current need for the WHO's role as a technical normative agency (standard-setting), as a provider of technical assistance (given that there are other providers), as an advocate and as an agency for inter-country collaboration (as in the International Health Regulations and in the control of epidemics)?

- There is also a need to differentiate between what the WHO should do, and what it, as currently structured, is capable of doing. The tendency to set up new institutions or activities outside the WHO has sometimes been a result of scepticism about its ability to deliver in practice, rather than a decision that such activities were not part of WHO's role.

- Similarly, WHO-based partnerships (such as Roll Back Malaria) could either be viewed as a logical way to involve multiple stakeholders in WHO activities, or as a not entirely successful escape from the WHO's bureaucratic embrace. It might also be suggested in the same vein that the WHO tried unsuccessfully to marry two different entities: WHO – an independent and authoritative technical agency devoted to promoting global public health and WHO Projects and Partnerships – a non-profit consultancy arm that executes projects and programmes that may or may not be intimately related to its core business.

- Some questioned the relevance of WHO reform to universal Health coverage. Conversely, did universal health coverage accurately encompass all the functions that the WHO should be undertaking?

WHO financing

- There is a fundamental misalignment in the WHO's financing between assessed contributions from member states and voluntary contributions. In the last WHO biennium (2010-2011) 21.8% of funding was from assessed contributions and 78.2% from mainly earmarked voluntary contributions from member states, and other funders (including foundations) whose importance had grown rapidly in the last ten years. Of the assessed contributions nearly 80% were allocated to staff costs, as compared to only 35% of voluntary contributions. Moreover it was argued by some that programmes funded by voluntary contributions imposed costs on the WHO's regular budget in excess of the standard overhead of 13% intended to support programme costs, which many donors were reluctant to pay in any case. Was there a way to match predictable funding to the WHO's core tasks, by raising assessed contributions, increasing predictability of voluntary funding, cutting costs or some combination of these?

- It was noted that the functions conducted at each level of the WHO needed to be compared with the costs of undertaking them, and that in general much greater transparency was needed regarding WHO budgets. The Geneva headquarters accounted for 42.5% of the WHO's total expenditure from assessed and voluntary contributions in the last biennium, approximately twice the amount of total assessed contributions. The WHO's country and regional operations therefore accounted for 57.5% of total expenditure. In the programme for 2012-13, the projected budget for country and regional programmes amounts to 67.3% of total expenditure.

WHO functions

- Much attention was devoted to the way the WHO was governed and operated at global, regional and country levels. In particular, what are its appropriate functions at each level?

- What functions could only be done at global level? These could include standard-setting, a forum for discussions between countries and other stakeholders based on its convening power, advocacy for public health, information collection and dissemination, analysis and surveillance, and promulgation of guidelines and good practices in diagnosis, treatment and prevention, and the development of health policy.

- What should be done at country level? What could only the WHO do and what could be done by others? Were WHO operations in each country correctly calibrated to that country's need for its assistance?

WHO regions

- What should be done at regional level? Was a regional structure necessary between the national and global levels?

- If so, why should the Regional Director be elected by regional members? This meant that governance was inevitably politicized. The costs and disadvantages of an election process in regional offices were noted, including the opportunities for patronage and unethical practices. It was noted that the same issues could also arise in respect of the election of the Director-General. It was necessary to identify the benefits and costs of a regional structure and, in parallel, the benefits and costs of regional heads being elected or appointed, including the implications for accountability of the two models.

- It was noted that the WHO constitution only specifies that the Director-General and Regional Directors should be appointed, respectively by the World Health Assembly and the Executive Board, and not necessarily elected by either the World Health Assembly or regional committees. Other methods of selecting and appointing the

Director-General and Regional Directors could therefore be considered consistent with the constitution.

- It was also noted that the composition of WHO regions was as much determined politically in the circumstances of the post-war world in 1948 as by natural congruity. Since then, regional organizations had emerged all over the world that bore little relation to WHO configurations or cut across them (e.g. the African Union, ASEAN, the European Union). Should WHO regions not be better aligned with organically evolved regional structures? The uniqueness of the composition of the WHO's regions isolated it from close partnerships with these new structures as they emerged. The Pan American Health Organization (PAHO) was an exception in that it was a creation of a predecessor of the Organization of American States (OAS), which was not affected by changing alliances after the Second World War, and relies mainly on contributions from member states and voluntary contributions it mobilizes on its own account, rather than, as in the case of other WHO regions, subventions from the WHO's regular budget and voluntary contributions.

Next steps

WG1 decided to pursue these ideas further and develop them into options for possible recommendations for consideration at the next meeting in Bangkok in April 2013.

A first exercise would be to examine in a systematic manner what functions needed to be performed by a global health body (GHB), as opposed to others, at the global, regional and country levels. For each potential function, the table below would need to be completed.

GHB Level	**Function (1, 2, 3...)**		
	GHB only	**Principally GHB**	**Anyone can do**
Global			
Regional			
National			

Second, further analysis needed to be done on the experience of the WHO with partnerships, and the prerequisites for success.

Third, there was a need for political analysis looking at the development of regional bodies developed principally for other reasons and how regional health concerns could be linked to these organic expressions of common regional interest.

Finally, an attempt needed to be made to sound out what countries really wanted from the WHO at each level.

Working Group 2

Working Group 2 also had a wide-ranging discussion stimulated by the presentation of the papers. It was noted that although development assistance had increased rapidly between 2000 and 2010 (from $76 billion to $124 billion) and development assistance for health (DAH) even faster (from $11 billion to $28 billion, including non-governmental assistance), it was estimated that DAH only amounted to 6% of total health spending in low- and middle-income developing countries. In low-income countries about 26% of expenditures came from external sources. The potential contribution of external resources to better health outcomes in developing countries should be seen

in this broader context, with due regard for the majority role played by domestic financing, even in the poorest countries.

Thus, discussion focussed on ways in which countries could raise more resources domestically for health and how resources could be used more efficiently for better health outcomes. Critiques of the current development aid system were addressed including: amounts falling short of commitments; volatility; conditionality and displacement of domestic resources for health; diverging priorities of donors and countries; costs imposed as a result of fragmentation of the system and issues to do with accountability. Consideration was given to ways in which resources could be mobilised internationally for health and alternative frameworks for resource flows within and between countries.

Issues discussed included:

Governance and accountability

- Who should be accountable to whom and through what mechanisms? Donor governments to their parliaments and recipient governments to their parliaments, but what if their priorities were different? How real, in fact, was the accountability of governments to their populations with respect to health expenditures in developing countries – the views of lawmakers, i.e. elected parliamentarians, and populations might well diverge? To whom were foundations, non-governmental organizations (NGOs) and the private sector accountable?

- Changes in policies, e.g. on HIV/AIDS or on tobacco, had been profoundly influenced by the actions of NGOs and civil society activists. This was a very important way of holding governments (and other actors), both in low-income countries and in donor countries, accountable in practice but begged questions as to the relationship between NGOs and the majority of the population, who might be ignorant of, agnostic about or even opposed to NGO demands.

Financing

- The many obstacles to, but also interesting possibilities for, improving predictability and reducing volatility – political, managerial and organizational.

- At the start of the decade, hopes were high regarding the role that private sector contributions could play. However, such contributions, for instance to the Global Fund, had never matched expectations. But money from non-profit foundations had obviously become increasingly important – and that funding is in part incentivised by tax breaks offered by governments.

- The appropriate role of 'new' donors, such as Brazil, China or India. How much should they contribute internationally as opposed to nationally to improve global health outcomes? It was noted that intra-country inequality was as important as inter-country inequality in determining where populations in most need of healthcare were mainly located.

- Why had the target of 0.7% of national income for development assistance only been reached by a few countries? In any case, there had been no analogous targets set for health spending. It was noted that an NGO campaign was suggesting 15% of development assistance (or 0.1% of GDP) should go to health.

- Whether the international financial system unduly constrained country choices regarding expenditure, including on health, either through the way globalization could erode the possibilities for taxation (and promote capital flight) or through restrictions imposed as a result of agreements with lenders such as the World Bank or International Monetary Fund.

- What determined how much countries spent on health? Why had some governments performed well (e.g. against the Abuja targets in which African governments committed to spend 15% of national budgets on health) but many others had not? The dominant

political culture was one factor – such as different emphases on collective and individual responsibilities – although this was not immutable in the longer term. The issue of 'fiscal space' to expand government spending was an important one.

- The evidence suggested that governments in part allow external aid for health to displace their own health spending. This could reflect several things, including reconciling the different priorities of the parties. If so, where did that released spending end up? That money could be spent on, for example, defence, or in other areas that benefitted health (e.g. education and water and sanitation) that were not prioritized by donors. A bigger question, particularly in relation to norms, was how much countries needed to spend on health, in terms of a basic package such as the amounts estimated by the CMH or Taskforce on Innovative International Financing for Health Systems? How could account be taken of spending on the social determinants of health or infrastructural investments such as water or sanitation or housing?

Raising revenues

- How could taxes or revenues best be raised in ways that were least regressive? What is the role of indirect taxation such as value-added tax? Are community-based financing or social insurance schemes viable means of addressing the needs of poor people and protecting them against financial risk? The evidence was mixed, and success or failure context-dependent.

- The possibility for raising more funding through 'sin' or other taxes, which might be hypothecated in part to new channels of international funding and health. Other possibilities discussed included special drawing rights or debt relief. One question was whether all these proposals for 'innovative financing' were simply a second-best way to convince policy-makers to devote more resources to development or health domestically, given their reluctance to do so through existing channels.

Coordination

- The extent to which the various mechanisms established for better coordination internationally or nationally (e.g. H8 group of international health agencies, the Paris Declaration or the International Health Partnership) had brought about real change. Similarly, mechanisms established to promote more rational priority setting had not been very successful in influencing donor behaviour. Moreover, the costs (both direct and transactional) of the proliferation of funders and partnerships at both the global level and acting at the national levels had not been properly established but were probably very substantial.

Alternative frameworks

- The relevance of alternative frameworks for mobilizing resources both nationally and internationally – particularly incorporating the notion of norms relating to GDP, development assistance and/or government expenditure.

- The relevance of human rights and the obligations of countries to fulfil them, including the right to the highest attainable standard of health. Could or should more specific commitments necessary to realise such rights and obligations be incorporated in some form of international instrument, governed either by 'hard' or 'soft' law? In that context what role should be played by incentives and was there a role for appropriate conditionality or sanctions if countries failed to meet obligations they had signed up to?

- Should there be thinking around new international mechanisms, such as a single global health fund, which could address both funding and coordination issues if it consolidated a number of existing health funders? On the other hand, developing countries' choice of funder would be more limited. Would they prefer one shop or 150 shops, or somewhere in between?

Next steps

WG2 decided on a work programme based on commissioning work on the following issues:

- The political economy of the factors underlying the decisions of some developing countries to increase domestic investments in health.
- The fiscal space for domestic financing of health, including potential quantitative norms for expenditures and the impact global economic institutions have on domestic financing. In addition it would be useful to examine where governmental budgets were reallocated when external financing displaced government expenditures on health.
- Quantitative norms for development assistance and that for health. Who should fund, how much, through which channels and for what?
- The relationship between external financing and domestic policies, financing, coverage or outcomes.
- The implications of creating an international pooled health financing mechanism – options and pros and cons.

The second meeting of the working group will discuss these additional background papers and will start identifying a potential set of recommendations based on existing evidence and feasibility of new approaches. Such recommendations may include different types of norms and standards, potential instruments for agreeing on and implementing them and mechanisms at the international and national levels.

Appendix: Working Groups composition

Working Group 1: WHO and the International System

Title	Name	Country	Affiliation
Dr	Viroj Tangcharoensathien	Thailand	Ministry of Public Health
Ambassador	Maria Azevedo **	Brazil	Geneva UN Ambassador
Professor	Fran Baum *	Australia	Flinders University/ People's Health Movement
Dame	Sally Davies	UK	Department of Health
Dr	Tim Evans *	Canada	School of Public Health, BRAC University
Professor	David Fidler	USA	Indiana University
Professor	Jane Halton	Australia	Department of Health and Ageing
Mr.	David Hohman	USA	Formerly Department of Health and Human Services
Professor	Peilong Liu	China	Ministry of Health
Dr	Precious Matsoso	South Africa	Ministry of Health
Ambassador	Tom Mboya *	Kenya	Geneva UN Ambassador
Professor	Anne Mills	UK	LSHTM
Dr	Sigrun Mogedal	Norway	Norwegian Knowledge Centre for the Health Services
Professor	Srinath Reddy	India	Public Health Foundation
Professor	Keizo Takemi *	Japan	Japan Centre for International Exchange

Working Group 2: Commitments to sustainable financing: need for a new model?

Title	Name	Country	Affiliation
Professor	John-Arne Rottingen	Norway	University of Oslo/Harvard University
Ms	Awo Ablo	Ghana/UK	International HIV/AIDS Alliance
Dr	Dyna Arhin-Tenkorang	Ghana	Formerly Ministry of Health
Dr	Christoph Benn	Germany	Global Fund
Professor	Ezekiel Emanuel*	USA	University of Pennsylvania
Dr	David Evans	Australia	World Health Organization
Dr	Luiz Eduardo Fonseca	Brazil	Fiocruz
Professor	Julio Frenk*	Mexico	Harvard University
Professor	Larry Gostin	USA	Georgetown University
Dr	David McCoy	UK	University College, London
Professor	Di McIntyre	South Africa	University of Capetown
Dr	Suerie Moon	USA	Harvard University
Professor	Gorrik Ooms	Belgium	Institute of Tropical Medicine
Dr	Toomas Palu*	Estonia	World Bank
Ms	Sujatha Rao	India	Formerly Ministry of Health
Dr	Devi Sridhar	USA	University of Oxford
Dr	Jeanette Vega	Chile	Rockefeller Foundation
Sir	Mark Walport*	UK	Wellcome Trust
Dr	Suwit Wibulpolprasert	Thailand	Ministry of Health
Mr	Simon Wright*	UK	Save the Children
Professor	Bong-Min Yang	Korea	Seoul National University

* Members unable to attend the first meeting on 8 and 9 October.

** Represented by Mr José Roberto de Andrade Filho, First Secretary, Permanent Mission of Brazil to the United Nations Office and other International Organizations in Geneva.