

Shaping the future of global health cooperation: where can we go from here?

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A review of recent studies and initiatives on global health cooperation groups their findings into ten key reform issues. In addressing these issues, policy makers need to improve their understanding of what is meant by the shift from international to global health. Attention must also be paid to the fundamental question of what we want from a system of global health cooperation. Three main views currently exist on what priority activities such a system should pursue—traditionalist, essentialist, and social justice. Reconciliation of these views can then be followed by consideration of the structural features of a global health organisation for the 21st century. Achievement of the above will require a reform process that is more broadly participatory, well-informed, and coherent in purpose and direction.

This series of seven papers has provided a timely review of the current status of health cooperation, and of the key challenges now stimulating debate in policy circles. We have seen what has changed since WHO was established 50 years ago—more agents, new knowledge and technology, shifting demographic and epidemiological profiles, and multifactorial ways of thinking about health. We have also seen what has remained unchanged—inequitable access to health care, persistent and increased poverty, resurgence of familiar diseases, violent conflict, environmental degradation, and limited health resources. The clear conclusion is that we must rethink—and, many argue, fundamentally reform—the goals and activities of present institutions to face old and new realities. So where can we go from here?

Since the early 1990s, a variety of studies and initiatives on the reform of international health cooperation have been carried out. This weight of research represents an emerging critical mass of understanding and political commitment to change. This final paper is based on a review of this research¹ and sets out the key issues now facing the international health community. Although many points of agreement exist, a lack of consensus remains on a wide range of issues and how to take them forward. Resolution of these issues, and the question of who resolves them, will determine the future shape of global health cooperation.

What are the key reform issues?

A review of 17 studies and initiatives² shows that several large and diverse conclusions and recommendations on reform have been proposed in the past 5 years. These proposals have served to inform the reform debate, but their number and variety make knowing where to begin a difficult task for policy makers.

One useful framework for advancement of the reform process is to group these findings into ten key issues or themes (panel 1). Some are “macro” issues—they are concerned with the overall goals of health cooperation.

Others are more “micro” in their focus—how to achieve agreed goals through improved institutional mechanisms and management practices. All are closely interlinked, with reform on one issue affecting other issues.

Panel 1: Key issues in reform of global health cooperation

Constitutional reform

What should provisions be of WHO's basic documents to frame organisation's purpose, functions, and proceedings?

Financing and financial management

What financial resources should WHO have to carry out its responsibilities, and how should they be most appropriately managed?

Governing bodies and governance

How should WHO's governing bodies be structured, how should they operate (ie, authority, membership, decision-making procedures), and what should be responsibilities in supporting global health cooperation?

Human resource/personnel management

What human resources should WHO have to carry out its responsibilities, and how should they be most appropriately managed?

Leadership of WHO

Who should provide leadership within WHO, what should be expected role of leadership, and how should leaders be appointed?

Mandate, functions and activities

What should WHO be doing? What should be responsibilities in global health cooperation?

Organisational structure

How should WHO be structured and operate as an organisation (eg, headquarters versus regions versus country offices)?

Programme management*: miscellaneous issues

What should be policies, procedures, and mechanisms used by WHO to define and carry out mandate, functions, and activities?

Reform process

How should process of reform of WHO, and global health cooperation more generally, be most appropriately taken forward in future?

Relations with other health-sector agents

How should WHO work most appropriately with other health-sector agents?

*This is a broad concept that concerns “the continuum from mandates to budgetary provision to implementation mechanisms through to reporting all closely related to outcomes in support of the mandate”.⁶

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Panel 2: Globalisation and health policy**Globalisation and disease**

How has globalisation affected epidemiology of disease within and across countries? Which diseases are most affected? What populations are most affected? What are implications for strategies for prevention, control, and treatment of disease? What are implications for International Health Regulations?

Global migration and mobility of people

How is spread and control of infectious disease affected by increased movement of people across national boundaries? What are health needs of globally migrant labour, (un)documented migrants, displaced people?

Global financing of health care

How will national governments pay for health care within globalised economy of mobile labour and capital? Can a global tax base exist? How has globalisation of finance influenced health financing? What global trends exist in health-sector aid?

Global trade and production

How should global trade and production be regulated to protect human health against infectious disease, industrial hazards, product safety, export of hazardous waste, &c? Can occupational health and safety standards be adopted globally? What implications do regional free-trade agreements raise for health care?

Global information and telecommunications

What impact are global communications having on provision of health services? What implications are raised by global inequities of access to such technologies? Are health needs represented in technological development? How can global communications be used more effectively to address health needs?

Global civil society and governance

Who are key agents and are they changing (eg, non-governmental organisations [NGOs], private sector)? To what extent is pluralism emerging in global health policy? Are existing international health organisations, notably UN, adequate to represent complexity of emerging interests? How can global power and global responsibility be balanced? What institutional mechanisms are needed to facilitate global policy process?

Global health law and legal system

Do international health regulations need to have "more teeth" to deal with global health issues? How can accreditation of health-care facilities and licensing and certification of health professionals be maintained in globalised context? What issues of intellectual-property rights (eg, pharmaceuticals, medical technology, and knowledge) need to be addressed?

What is meant by global health cooperation?

Almost everyone recognises that the context of health policy has changed dramatically over past decades. Among these changes, perhaps the most fundamental has been the process of globalisation. A word coined in the early 1970s to describe the increased influence of multinational corporations,³ "globalisation" today has a seemingly endless range of meanings. The word thus remains vaguely defined, and poorly understood.

In the health sector, the impact of globalisation is now just being explored by researchers and policy makers. What does the shift from international to global health actually mean? Although often used interchangeably, "international", strictly speaking, is traditionally defined by relations between States and their governments (intergovernmental). "Global" encompasses relations beyond governments and includes individuals and groups within societies that interact across national boundaries, such as transnational corporations (TNCs), non-governmental organisations (NGOs), and religious movements.⁴ "Globalisation" can be understood as the

process by which human societies are moving from international to global relations. This movement is arising out of the new technologies of the so-called "postindustrial society",⁵ including information and communication technologies.

The "shrinking" of the world, from a system of 190 separate countries to a more complex entity of dependent and interdependent individuals, groups, and countries, has direct implications for health policy—the most important being the emergence of health issues created by globalised relations. Some issues, such as control of infectious-disease transmission, are familiar difficulties given a new twist by globalisation; others, such as regulation of the impact of the global economy on health, have arisen as a direct result of globalisation. In reforming the current system of health cooperation, policy makers must take a range of global issues into account (panel 2).

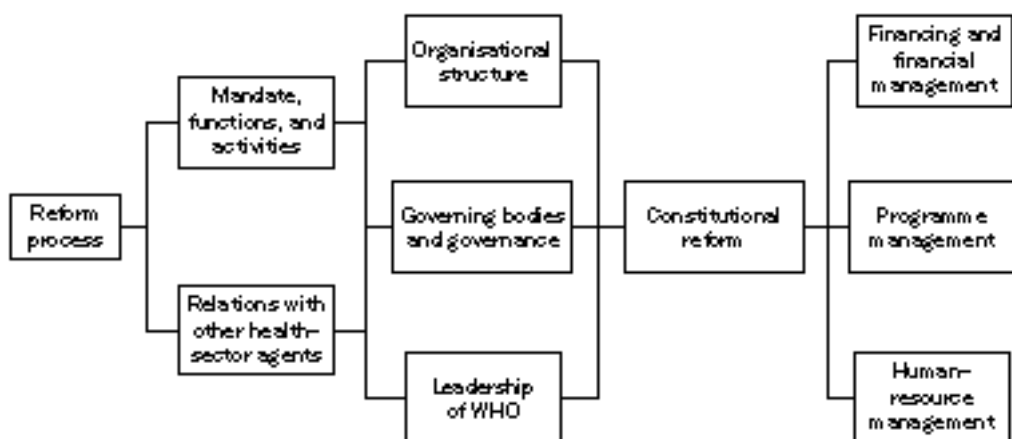
What do we want from global health cooperation?

Although management issues have frequently dominated criticisms of WHO and the United Nations (UN), the creation of an efficient and effective system of health cooperation must begin with a more fundamental question: what do we want from such a system? This is more difficult to answer than it may at first seem, and is perhaps the most difficult question of all owing to the need for consensus on the basic principles by which the goals and activities of health cooperation can be defined. Is health a human right or an economic privilege? Does the achievement of health development need an economic rationale, or is it of value in itself? Does the work of a global health organisation depend on the question "what's in it for me?", or is there still room for benevolence?

Whether values and principles can be universally agreed at all is also debatable. The health sector is a diverse constituency. The search for consensus on what is wanted is akin to current debates on the rationing of health services at national level. Although scientific methods (eg, evidence-based medicine, burden of disease or disability-adjusted life years [DALYs]) can be useful in some situations, the process is invariably political, and takes place amid many competing, and sometimes irreconcilable, interests. Limited resources need to be allocated among unlimited demands. The challenge lies in the reconciliation of the different value-systems and interests that make up the global health community.

Once a set of principles to guide health cooperation has been agreed, what should be the corresponding contribution of a global health organisation to achieving them? When WHO was founded in 1948, its creators intended its mandate to encompass the pursuit of health in the broadest possible sense. 50 years on, most agree that this intention is neither feasible nor desirable. There is a consensus that WHO should focus more on priority areas—but what should these priority areas be?

Three main positions exist. First, the traditionalist view, which harkens back to WHO's glorious (and perhaps glorified) past, when the organisation focused on so-called "normative" knowledge-based activities. Although recognition of WHO's broad definition of health and universal membership is incorporated in this view, the traditionalist view holds that the organisation should restore its former emphasis on facilitating the creation and application of health knowledge. WHO should not,



Suggested framework for discussion of key WHO reform issues

according to this view, directly engage in health development—commonly referred to as technical-cooperation activities—since it departs from WHO’s original mandate.⁶ Critics of the traditionalist view argue that the organisation must be relevant to all member states, including a large number of developing countries that need development assistance. Others dispute WHO’s historical emphasis on biomedicine, which they argue is inadequate in the face of the varied and complex health issues in the world today.⁷

The second position—the “essentialist” view—concentrates only on the health needs of a global community. This view holds that WHO should undertake only those responsibilities that affect other countries, and that member states cannot, or will not, fulfil them if acting alone. These “core functions for which international organisations have a comparative advantage over national entities” include transborder disease control, coordination of a global health information system, and regulation of global health externalities.⁸ In the promotion of health around the world, national interests are also believed to be protected.⁹ Critics of this approach, however, see this “reductionist” or “minimalist” view of international organisations as a parallel to the ideology-driven shrinking of governments at national level.¹⁰ In addition, the activities proposed to be retained are rejected by such critics as being only those driven by self-interest, which enable the current winners in the global political economy to continue to prosper.

Third, and in contrast to the first two views, the goal of the social-justice view is to “reintegrate health policies with development strategies”.¹¹ This view represents a more interventionist role, with responsibilities for the mobilisation and reallocation of health-sector aid, advocacy of principles of social justice (ie, as the world’s “health conscience”), provision of scientific and technical expertise to countries in need, the targeting of vulnerable groups (eg, ethnic minorities and women), and the monitoring and reporting of the practices of big business and government.¹²

The advocates of the pared-down essentialist view, and the bulked-out social-justice view, remain divided—geographically, financially, and philosophically. Reconciliation of these differences remains an elusive goal.

The building of a global health organisation for the 21st century

Despite frequent criticism of the UN since the end of the

Cold War, together with serious doubts about its continuing relevance, almost all agree that health cooperation should remain a central component of any future system of global governance. Whether based on the status quo, essentialist views, or social-justice views, health cooperation in some form is necessary. But what should the structural features of a global health organisation be in the 21st century?

Several ideas for the renewal or rebuilding of WHO and other relevant organisations have been proposed. One key question is whether a single health organisation should exist—encompassing broad responsibilities—or several different organisations with an agreed division of labour. At present, there is neither. The perennial difficulty of poor coordination among different agents continues to detract from effective health cooperation.¹³ The existence of health organisations that are independent of one another, and independent of any single higher authority, must be changed if a more strategic allocation of responsibilities is to be achieved.

Another difficult question is how to distribute authority within a system of global health cooperation. In a system of more than one organisation, should there be a lead agency? What would this mean in practice, and how could this role be enforced? In principle, WHO is described as the leading international health organisation, but in practice this status has often been challenged by the initiatives of other institutions.

Consideration must also be given to how the weighting of authority within individual organisations. Once again, diversity rules at present. WHO currently consists of headquarters and regional and country offices, with decision-making power firmly placed at headquarters and at regional levels. The World Bank is even more centralised at headquarters, with country-level activities primarily carried out by visiting missions. The United Nations Children’s Fund (UNICEF) follows a more decentralised model by means of substantial devolution of authority to its regional and country offices. Can these assorted models—based on historical, philosophical, and operational differences—be united?

Finally, a system to provide secure and adequate financing of global health cooperation is needed urgently. The incomes of international health organisations have primarily come from assessed (mandatory) and voluntary contributions. Can these sources be diversified? Suggestions for alternative sources of funding include taxation or levies on global activities (eg, travel and

financial transactions). But governments remain divided over who should pay, and how much. Must a culture of self-interest prevail, or does altruism still have its place?

Reform of the reform process

In conclusion, the most immediate challenge for reform of the present system of health cooperation is the reform process itself. Above all, the process needs to be more inclusive in terms of who participates; better informed; and more coherent in purpose and direction.

First, the reform process has not been sufficiently representative of the diversity of interests in the health sector. By relying on the "same old faces", we may be limiting the discussion to a narrow range of difficulties and solutions. If reform is to produce a relevant and effective system of health cooperation, the traditional emphasis on governments to represent member states must be supplemented to include, for example, non-governmental organisations, citizens' groups, health professionals, and business interests. The "People's Assembly" proposed by the new UN Secretary-General to participate in "preparing the United Nations to meet the major challenges and needs of the world community in the 21st century" is an idea that could be taken up within the health sector. Only through provision of opportunities for all stakeholders to contribute meaningfully to the reform debate can real dialogue on reform begin.

Second, a reform process offering greater participation must be accompanied by a well-informed constituency. Although there has been much recent publicity about the shortcomings of the present system of health cooperation, less is understood about the specific challenges and how to tackle them. Empirical analysis continues to be necessary. Wider distribution of some of the works already discussed may also be useful.

Finally, the reform process needs clearer purpose and direction. The key reform issues can be organised into a framework and addressed sequentially (figure). The

framework shows that although management difficulties have been the target of frequent criticism, they can be viewed as symptomatic of "higher level" issues concerning the leadership and goals of health cooperation. These latter issues could be addressed at a high-level meeting similar to the International Health Conference of 1946, which led to the creation of WHO.

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