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Democratization and Universal Health Coverage: A Case Comparison of Ghana, Kenya, and Senegal

Karen A. Grépin and Kim Yi Dionne

This article identifies conditions under which newly established democracies adopt Universal Health Coverage. Drawing on the literature examining democracy and health, we argue that more democratic regimes – where citizens have positive opinions on democracy and where competitive, free and fair elections put pressure on incumbents – will choose health policies targeting a broader proportion of the population. We compare Ghana to Kenya and Senegal, two other countries which have also undergone democratization, but where there have been important differences in the extent to which these democratic changes have been perceived by regular citizens and have translated into electoral competition. We find that Ghana has adopted the most ambitious health reform strategy by designing and implementing the National Health Insurance Scheme (NHIS). We also find that Ghana experienced greater improvements in skilled attendance at birth, childhood immunizations, and improvements in the proportion of children with diarrhea treated by oral rehydration therapy than the other countries since this policy was adopted. These changes also appear to be associated with important changes in health outcomes: both infant and under-five mortality rates declined rapidly since the introduction of the NHIS in Ghana. These improvements in health and health service delivery have also been observed by citizens with a greater proportion of Ghanaians reporting satisfaction with government handling of health service delivery relative to either Kenya or Senegal. We argue that the democratization process can promote the adoption of particular health policies and that this is an important mechanism through which democracy can improve health.

INTRODUCTION

Why should we expect democracies to be more responsive than non-democracies to the health needs of their citizens? How does the democratic process influence the particular health policies adopted by democratically elected governments? A number of empirical studies show democracies have higher levels of health and access to health services,¹ however the exact mechanisms through which democracy improves health have been less well established. In theory, electoral competition found in democracies is one potential mechanism: the threat of losing office via elections motivates politicians to seek policies that will gain voter approval and politicians will appeal to the electorate by advocating particular policies to influence voting. The extent to which politicians must appeal to a broader segment of the voting population should make them more likely to adopt policies that benefit a broader proportion of the population.²

This article contributes to the literature on democracy and health by identifying the conditions under which newly established democracies adopt a particular type of health policy: Universal Health Coverage (UHC). We argue that

it is not simply the level of democracy that makes governments more likely to adopt health policies that benefit the population broadly, but rather the extent to which democratic development is perceived as meaningful by citizens and is manifested in electoral competition that puts pressure on political parties to pursue universal, rather than more targeted, health policies.

Our study draws largely from the Ghanaian experience. Ghana was among the first developing countries in sub-Saharan Africa to enact what would today be described as UHC legislation. Although coverage today remains less than universal, the expansion of health insurance coverage, the utilization of health services, the levels of population health, and the proportion of the population who report satisfaction with the government's performance on health have all increased. Ghana is considered a leader among developing countries in providing UHC to its citizens.

Over the past two decades, Ghana has also transformed itself from a largely autocratic to a largely democratic country with strong political competition. Political scientists have heralded Ghana as a leading example of democracy in Africa today. In this paper we assert that the simultaneity of Ghana's democratization and pursuit of UHC is not a coincidence: the movement towards democratic government in this country was essential to the expansion of health insurance coverage. However, democratization alone does not fully explain the decision to adopt an ambitious UHC policy. Instead, we argue the extent to which citizens perceive democratic governance and the extent to which political parties in Ghana have been subject to electoral competition led to the decision to adopt a policy that broadly benefits a large proportion of the population, rather than using more targeted approaches to health financing reform.

Unlike vaccine programs, clinic construction, or user-fee exemptions, for example, UHC policies cannot be targeted to particular geographic areas or to particular ethnic groups. Since the goal is to provide *universal* coverage, policies are designed to include as many citizens as possible, which could lead to more equal and comprehensive access to health services. Drawing on the literature examining democracy and health, we would thus expect more democratic regimes – in particular those where citizens have positive opinions on democracy and where competitive, free and fair elections put pressure on incumbents – to choose health policies that target a broader proportion of the population. We also expect this democratic provision of services will have a stronger and more positive impact on health outcomes in these countries, since governments have the most incentive in these countries to ensure the success of these programs.

To examine this argument, we compare Ghana to two other African countries that have seen similar increases in aggregate measures of democracy: Kenya and Senegal. Although aggregate measures rate these three countries similarly with respect to democracy, the three cases vary on public opinion toward democracy and have experienced different levels of effective electoral competition in the multiparty era. We argue that the different nature of democracy in Ghana is part of the reason that Ghana has adopted UHC while the other countries have not. We also argue that such policy adoption has led to greater improvements in health outcomes and greater public satisfaction with government handling of health issues.

In the next section, we motivate this discussion with a review of the literature on the relationship between democracy and health. We then discuss the methods we employ in our case comparison of Ghana, Kenya, and Senegal, including the case selection process and the data used in the case studies. Our case comparison then follows in five sections: first, a comparison of the democratization process; second, a discussion of public opinion of democracy in those countries; third, a comparison of the evolution of health insurance in those countries; fourth, a comparison of health care utilization and health outcomes; and finally, a comparison of public satisfaction with government performance on health service delivery. The final section discusses our findings and some implications for other developing countries currently considering the adoption of UHC policies and concludes.

BACKGROUND

The relationship between democracy and health

The literature on the role of democracy in improving the human condition often examines democracy's impact on provision of social services, such as health and education, and the provision of public goods, such as electrification and roads. Using time-series cross-sectional analyses, Lake and Baum found that democracies produce a higher level of health and education services than autocracies.³ Brown and Hunter found in Latin America that democracies allocate a greater share of resources to primary education.⁴ On the expansion of electricity to previously unconnected citizens, Min used data from satellite imagery to show that democratization has a positive impact on electrification cross-nationally, within India, and across countries in the former Soviet bloc.⁵

Empirical studies have also found democratic rule leads to improved health outcomes. Democracy is correlated with improved health and healthcare access.⁶ Cross-national analysis shows democracies have lower infant mortality rates than non-democracies,⁷ and the same holds true for life expectancy⁸ and maternal mortality.⁹ Dictatorship, on the other hand, depresses public health provision, as does severe income inequality, ethnic heterogeneity, and persistent international conflict.¹⁰ At least one study, however, has questioned these empirical findings. Ross found that previous analyses were sensitive to the countries included in the models and even in democracies, where governments spend more on health, the reduced infant and child mortality rates are largely transferred to the middle class, and not the poor.¹¹ Given the findings of Ross, we need a better understanding of the mechanisms through which democracies improve health and whether the "democracy" effect is universal.

Stasavage is more explicit about a mechanism through which democratization impacts social spending in his study of education spending in Africa: when rulers are faced with the need to garner an electoral majority in order to win or maintain office, they spend in ways that will assist with that goal, namely, in the provision of a universal public good.¹² This is particularly salient in contexts immediately following competitive elections.¹³ Brown and Mobarak make explicit the link that in democracies politicians are compelled to favor

wider segments of the population, and they show that democratic governments increase the residential sector's share of electricity consumption (relative to industry's share).¹⁴

The threat of losing office incentivizes government to greater effort,¹⁵ particularly towards more visible public goods provision.¹⁶ The abolition¹⁷ of primary school fees is one such "visible" good, especially when compared to other education inputs governments can choose to improve, such as hiring more teachers.¹⁸ We argue UHC is another such "visible" good that a politician could use as a campaign promise (or instrument while in power) to generate broad electoral support.

Other scholars have also made the connection between electoral competition and health policy reform. Carbone studies Ghana before and after democratization and argues the political competition associated with democratization was the primary influence in the health financing reform process.¹⁹ However, Carbone does not fully address the particular policy design choice: that of UHC rather than less ambitious and more selective or targeted approaches to health financing reform.

Before and after democratization swept much of the African continent in the 1990s, politicians often chose to target distribution of public goods and services (including those related to health), particularly to groups tied to the president's ethnicity.²⁰ We argue that true democratic competition, rather than more fragmented electoral competition, can induce political parties to adopt health policies that are more likely to target a broader portion of the population and are more universal in nature.

DATA AND METHODS

Approach

Like Stasavage, we expect electoral competition is a primary mechanism through which democracy impacts health policy choices (and ultimately, health outcomes). Our study does not test this theory directly but explores the conditions under which democracies adopt UHC. We compare three cases to illustrate the hypothesis that electoral competition affects UHC policy choice and explore the impact of public attitudes toward democracy on UHC policy choice.

To find evidence for the argument that public opinion and electoral competition, and not just the development of democracy itself, lead to policy aimed at a broader constituency, we compared sub-Saharan African countries in terms of their Polity 2 scores and selected countries that have experienced similar increases in levels of democracy over the same time period as Ghana, the anchoring country for our analysis. Using a 21-point scale ranging from -10 (hereditary monarchy) to +10 (consolidated democracy), the Polity 2 score captures the combined qualities of democratic and autocratic authority in governing institutions.²¹ We excluded small island countries from the sample due to the small populations. Of the remaining countries, Kenya and Senegal were both countries in which multiple waves of Afrobarometer survey data was

collected and in which there were sufficient Demographic and Health Surveys (DHS) to make comparisons on outcomes over the relevant time period.

Data

To compare the countries' democratic profiles we rely upon survey data from two different sources: the Afrobarometer and Gallup World Poll surveys, both of which measure public attitudes toward democracy. The Afrobarometer, a public opinion survey that draws nationally representative samples of adults in 20 African countries, provides data²² that tracks satisfaction with democracy in Ghana, Kenya, and Senegal from 2002 to 2008.²³ In particular, we analyze responses to questions about satisfaction with how democracy works²⁴ and evaluations of the democratic nature of a country.²⁵ In our analysis of public satisfaction with health service provision, we also draw on data from Afrobarometer that asked respondents to evaluate government performance on improving basic health services.²⁶ We complement the Afrobarometer data with data from the 2011 wave of the Gallup World Poll, which conducted public opinion surveys with nationally representative samples in Ghana, Kenya, and Senegal.²⁷ The Gallup World Poll targets the entire civilian, non-institutionalized population aged 15 and older in the 130 countries where Gallup collects data. Samples are probability-based and nationally representative. There is a standard set of core questions used across the countries. We analyze data on confidence in government,²⁸ perceptions of government corruption,²⁹ and confidence in the honesty of elections.³⁰ Finally, we reviewed the published scholarly literature on elections in Ghana, Kenya, and Senegal, as well as country profile reports from the Economist Intelligence Unit to flesh out the electoral competition profiles of each country.

To measure health and health system improvements, we employed data collected in successive rounds of the Demographic and Health Surveys (DHS). The DHS are nationally representative surveys of reproductive-age women collected in developing countries on a regular basis.³¹ The DHS uses very similar questionnaires across countries and across rounds of surveys, allowing cross-country comparisons of indicators and the analysis of trends in indicators. The indicators selected for comparison in this paper are commonly used measures of health service utilization and health outcomes, including whether or not births reported within the last three years of the survey were attended by a doctor or other health professional, whether or not births which took place within the last three years of the survey took place in a health facility, whether or not children aged 12-23 months had received all recommended childhood vaccines, and whether or not children born within the last three years who had suffered diarrhea within the last two weeks prior to the survey were treated with Oral Rehydration Therapy (ORT). The main health outcome variables utilized in this comparison were infant mortality rates and under-five child mortality rates.

CASE COMPARISON OF GHANA, KENYA AND SENEGAL*Comparison of the evolution of democracy*

Though Ghana was the first sub-Saharan African country to achieve independence from its British colonizers and though it was originally a democracy, Ghana faced a series of coups and was authoritarian for much of its post-independence history. Scholars consider the transition to multiparty democracy in 1992 as the start of the democratic period in Ghana. A new constitution and multiparty elections, which were adopted in 1992, marked the beginning of the Fourth Republic, Ghana's current democratic regime.

On December 31, 1981 Jerry John Rawlings, a former military officer and charismatic leader, took power in Ghana through a coup. His party, called the Provisional National Defense Council (PNDC), was a largely left-leaning party. As part of the transition to multiparty elections in 1992, Rawlings officially retired from the military and formed the National Democratic Congress (NDC), which won the first multiparty election. The NDC ruled Ghana from 1992-2000.

Elections are held every four years in Ghana. Since the establishment of multi-party elections, only two major political parties have had any real probability of winning the presidency: the NDC, which although still left-leaning is more accurately described as a center-left party, and the New Patriotic Party (NPP), the center-right party. In 2000, the NPP narrowly defeated the NDC leading to the first change in power in Ghana that has come through electoral defeat. John Agyekum Kufuor took over the Presidency of Ghana in early 2001. Two elections later in 2008 the NDC, now led by John Evans Atta Mills, the former Vice-President of Ghana during the Rawlings Presidency, narrowly defeated the NPP to once again claim the Presidency in Ghana. The 2000 and 2008 presidential races were so close that in both years runoff elections were held because no candidate won 50% of the vote in the first round.

Although ethnic and tribal considerations are important in Ghana, voting patterns in Ghana do not fall exclusively along ethnic or tribal lines. Rawlings is half Ewe and half Scottish. The NDC party, which was formed by Rawlings in 1992, has benefited from the loyal support of the Ewe and the Volta Region from which Rawlings hails.³² Historically, the Ghanaian intellectual and business elite have come from the Ashanti area. The NPP emerged from this region and therefore has maintained relatively loyal support from the Ashanti region as well as from the Eastern Region.³³ However, outside of these strongholds, populations are more heterogeneous, being composed of Ashanti, Ewe, Ga, and other ethnic groups such as the Fanti. These ethnically diverse areas have experienced relatively strong electoral competition.³⁴ Whitfield argues the *de facto* two-party system in Ghana has allowed parties to cut across social cleavages such as ethnicity and create institutional networks in all regions of the country.³⁵ In sum, Ghana has been heralded as an exemplary democracy that other transitional democracies should aspire to replicate.³⁶

Kenya was predominantly a one-party state following independence in 1963 and transitioned to a multi-party system in the 1990s. Daniel Arap Moi of

the Kenya African National Union (KANU) party ruled Kenya from 1978 until 2002, when the constitution barred him from running again. His hand-picked successor, Uhuru Kenyatta, lost the election and the presidency was – for the first time since independence – ruled by someone outside of KANU: Mwai Kibaki, the presidential candidate of the National Rainbow Coalition, which was a combination of the Liberal Democratic Party and the National Alliance of Kenya. Though some date Kenya's democratization process to have started with the advent of *de facto* multipartyism in the 1990s, other scholars debate this date given that it was not clear that Moi or KANU would concede victory to the opposition. This further strengthens the importance of the 2002 elections in Kenya's democratization process.

Ethnic ties are significant in contemporary Kenyan politics. The ethnic violence surrounding the 2007 elections is an obvious example of how some ethnic boundaries in the country also map onto political divisions.³⁷ Ethnopolitical divisions that erupted into violence in the 1990s were "forerunners" of the 2007 election violence, demonstrating a history of the salience of ethnic division rather than an original, isolated incident.³⁸ The 2007 election irregularities and subsequent violence has further deteriorated the already low levels of trust and social capital across ethnic groups.³⁹

Though a recent Economist Intelligence Unit Country Profile of Kenya gives the country relatively high marks on the political participation component of its democracy index, the editors caution, "Healthy participation is undermined by the significance of ethnic allegiances in Kenyan politics and the disproportionate power wielded by dominant tribes."⁴⁰ A new constitution, approved by referendum in 2010 by a two-to-one margin, calls for greater devolution of power, a new anti-corruption agency, and an independent land commission; the hope is that following the implementation of the new constitution, the issues undergirding ethnic tensions in Kenya will be addressed.⁴¹

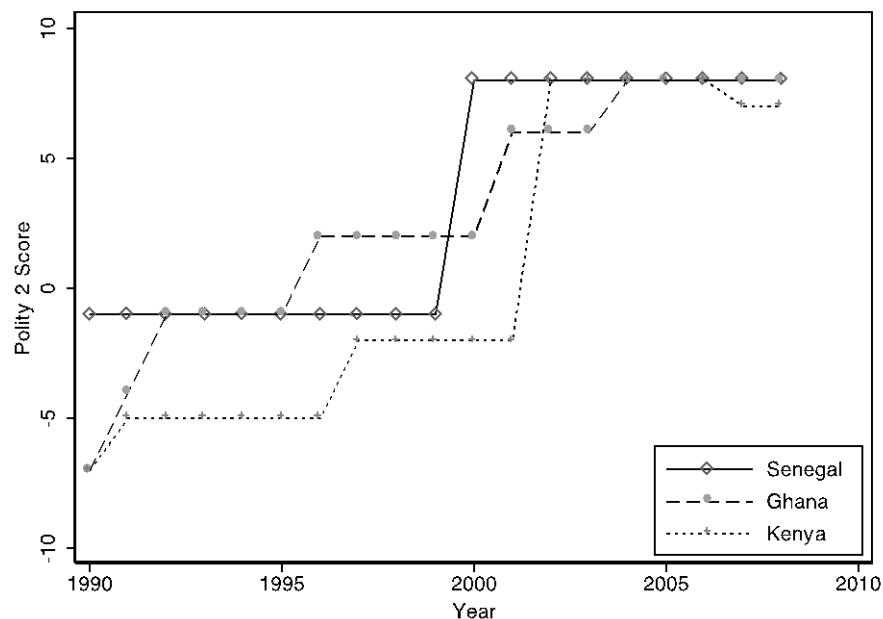
Following independence from France in 1960, Senegal was dominated by a single party, the Parti Socialiste du Sénégal (PSS), originally led by the founding president Léopold Senghor. When Senghor retired in 1981, he handed over power to his deputy, Prime Minister Abdou Diouf. The quasi-single party rule came to an end in 2000 when the incumbent Diouf lost the election to Abdoulaye Wade, the presidential candidate of the Parti Démocratique Sénégalaïs (PDS). Wade won reelection in 2007 but lost his bid for a third term in March 2012 and peacefully transferred power to Macky Sall, who ran as a member of the Alliance pour la République (APR) party.⁴² Thus, like Ghana, Senegal has experienced two peaceful transfers of power in the contemporary democratic period. However, elections in Senegal have not been as competitive as those in Ghana. Wade won the 2007 election by a margin of 41% and lost the 2012 election by a margin of 31.6%.

Ethnic division is not prominent in Senegalese politics,⁴³ though the conflict in the Casamance region has sometimes been interpreted through an ethnic or religious lens. More than 90% of Senegal's population is Muslim. The largest ethnic group in Senegal is the Wolof (43% of the population) and the next largest is the Peuhl (24%). Political parties have not formed along ethnic lines,

though are characterized as elitist.⁴⁴ The most recent Economist Intelligence Unit Country Profile of Senegal characterizes political participation as weak because of low literacy rates, high poverty, and the lack of women's involvement in political life.⁴⁵

Thus, all three countries examined in this case comparison have undergone the transition to single-party to multi-party elections over roughly the same time periods. The democratization of Ghana, Kenya, and Senegal from the 1990s to the current period is illustrated in Figure 1, which tracks the Polity 2 Score from the Polity IV dataset.⁴⁶ All three countries began the 1990s with a Polity 2 score below 0, indicating higher levels of autocratic institutions than democratic institutions. The figure shows countries ending with Polity 2 Scores of 8 (Kenya reverts to 7 in 2007 and 2008), indicating higher levels of democratic institutions than autocratic institutions. The tentative 2010 Polity scores suggest similarity as well, with Ghana and Kenya both scoring an 8 and Senegal at 7.⁴⁷

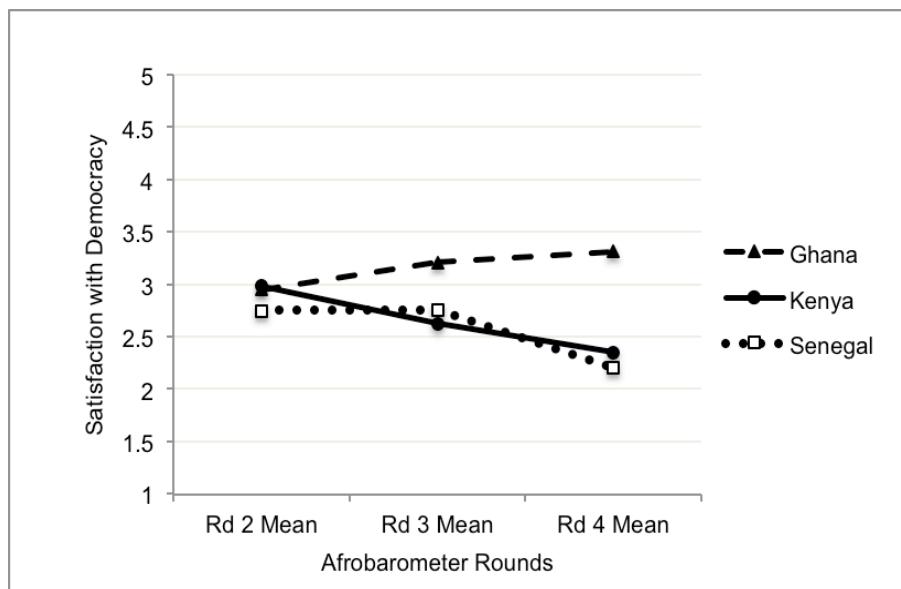
Figure 1: Level of Democracy in Ghana, Kenya, and Senegal 1990-2008



Comparison of electoral competition and public perception of democracy

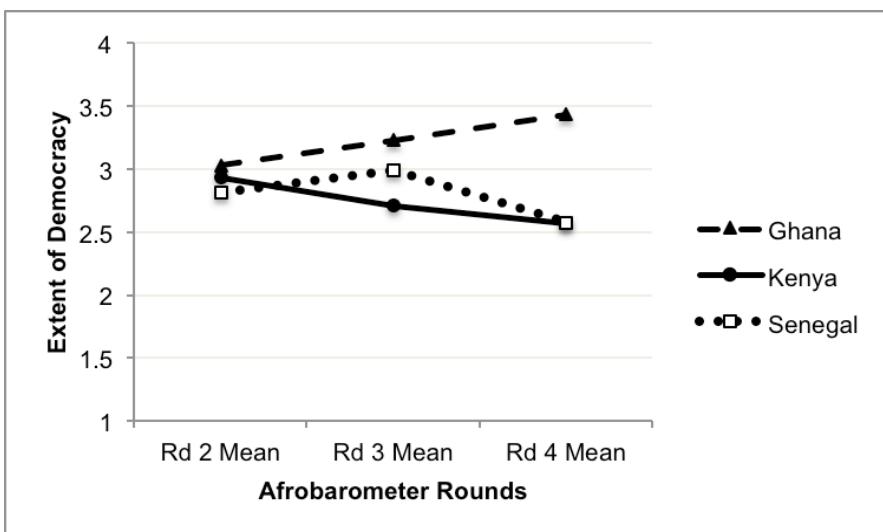
Using a 5-point scale ranging from 1 (very unsatisfied) to 5 (very satisfied), Figure 2 illustrates the average level of satisfaction with democracy in each of the countries in Rounds 2, 3, and 4 of Afrobarometer data collection. All three countries started roughly at the same point in Round 2, when Kenya's average satisfaction with democracy score was 2.98, Ghana's 2.95, and Senegal's 2.75. Over time, however, we see a decline in the satisfaction with democracy in both Kenya and Senegal, and a slight rise in the average Ghanaian's satisfaction with democracy.

Figure 2: Satisfaction with Democracy in Ghana, Kenya, and Senegal, Afrobarometer Rounds 2-4



Regarding the extent to which Afrobarometer respondents think their country is a democracy, the response pattern over time is similar to the question about satisfaction with democracy. On a scale of 1 (not a democracy) to 4 (a full democracy), all three countries cluster around the same point during Afrobarometer Round 2; Ghana has a mean of 3.0, Kenya has a mean of 2.9, and Senegal has a mean of 2.8. Over time, however, we see a divergence (see Figure 3). By the time Afrobarometer collected Round 4 data, Ghanaians' average opinion on the extent of democracy in their country had improved (mean of 3.4), while the average opinion in both Senegal (mean of 2.6) and Kenya (mean of 2.6) declined.

Figure 3: Extent of Democracy in Ghana, Kenya, and Senegal, Afrobarometer Rounds 2-4



Gallup World Poll data from 2011 indicate more Ghanaians (68%) reported having confidence in their government than Kenyans (46%) or Senegalese (30%). Though belief that government was corrupt was a majority opinion in all three countries, this opinion was more prevalent in Kenya (96%) and Senegal (89%) than in Ghana (82%). Perhaps the most relevant indicator from the Gallup World Poll is a question that asked about the honesty of elections. In Ghana, 75% of the surveyed population thought elections were honest, while only 36% of Senegalese and 27% of Kenyans thought elections were honest.

In sum, nationally representative samples surveyed by two different public opinion outfits show far more variation in democratic indicators between Ghana, Kenya, and Senegal than the overall Polity scores would suggest. Judging from the public opinion data, Ghana is perceived to be the most democratic of the three countries by regular citizens, and by a significant margin.

A cornerstone of democracy is the institution of free and fair elections. Though all three countries have held elections since gaining independence, only in the 1990s did Ghana, Kenya, and Senegal all have true multiparty competition. It was not until the 2000s, however, that these countries also experienced alternations in power, meaning a peaceful transfer of power from one political party to another in ruling the presidency. In 2000, Senegal's long-standing ruler Abdou Diouf (of the PSS) lost his re-election bid and handed over the presidency to Abdoulaye Wade (of the PDS). In Ghana in 2000, the hand-picked successor to Jerry Rawlings, John Atta Mills (of the ruling NDC party), lost to John Kufuor (from the opposition NPP) and power was peacefully transferred to Kufuor in 2001. Kenya's election in 2002 of Mwai Kibaki (of the National Rainbow Coalition) ended decades of rule by the KANU party, after the loss of outgoing President Daniel Arap Moi's hand-picked candidate, Uhuru Kenyatta, and again, the handoff of power was peaceful.

The trend of competitive, free and fair elections followed by peaceful alternation in power continued only in Ghana. In Ghana's 2008 election judged by international and domestic observers as free and fair, the opposition won by only a narrow margin (of less than one percent), but the ruling party conceded defeat and handed over power.

In contrast to the Ghanaian experience, Kenya's 2007 election was followed by violence that resulted in over 1,000 deaths and the displacement of an estimated 350,000 people. Though polls preceding the election showed a close race where the opposition candidate Raila Odinga would defeat the incumbent president Mwai Kibaki,⁴⁸ the Electoral Commission of Kenya declared Kibaki the winner, stating he won 46.4% of the vote while Odinga only garnered 44.1% of the vote. International and domestic election observers described the election as flawed.⁴⁹ Analysis of exit poll data against officially reported election returns show discrepancies beyond margins of error.⁵⁰ The alleged fraud associated with the ballot counting and the violence surrounding the 2007 elections precipitated the drop in Kenya's Polity score seen in Figure 1.

Senegal also held elections in 2007. Though opposition parties protested the outcome of the presidential election, electoral observers declared the balloting sufficiently free and transparent.⁵¹ The incumbent, Abdoulaye Wade,

won 55.9% of the vote in the first round; the nearest challenger, Idrissa Seck, won only 14.9% of the vote. Wade lost his bid for a third term in March 2012, having only received 34.2% of the votes in the second round, while winner Macky Sall won 65.8% of the vote. Though Senegal's 2007 and 2012 elections had no violence or sufficient tampering to have altered the outcome, the results – particularly the wide margins of victory – demonstrate the absence of real competition.

The election in Senegal was not competitive like that in Ghana, where as the election in Kenya was competitive but was not free and fair. So, unlike the overall Polity scores, and more consistent with the public opinion data, analysis of recent elections in Ghana, Kenya, and Senegal show variation in the democracies. In particular, the elections demonstrate that only in Ghana were politicians faced with real uncertainty about who would win office. Because of the genuine competitive nature of politics in Ghana's democracy, it is unsurprising that Ghana, and not Kenya or Senegal, has chosen to pursue UHC, a policy that would garner broad electoral support. Senegal's Wade, faced with weak opposition, had little incentive to pursue a policy that would attract more voters (he had a sufficient number of voters already). Kenya's Kibaki, having decided the outcome irrespective of the actual election results, also lacked incentive to pursue a policy with universal benefits: if you can rig the election, what does it matter what policy would benefit voters?

Comparison of health reform process

Due to a combination of changing economic conditions and increasing role of international actors in influencing health priorities in developing countries, most countries in sub-Saharan Africa adopted some sort of user-fee system in either the late 1980s or early 1990s.⁵² Although it was realized that user-fees were likely to disproportionately affect lower income patients, such policies were adopted on the basis of the need to raise financial resources for health service delivery, to improve the quality and availability of commodities, and to promote the sustainability of health systems. In theory, most countries also adopted some sort of exemption policy to exempt low-income patients from these user-fees. In practice, most of these exemption policies were poorly implemented and essentially non-functional.⁵³

Beginning in the late-1990s, there was a growing recognition of the need to implement alternative financing schemes. Although user-fees were ubiquitous, these policies were unpopular in many countries and at the same time, health indicators were not seen to be sufficiently improving in most countries. International partners and developing countries alike became more interested in the idea of implementing some form of health insurance system to expand financial protection and increase health service utilization, in particular among the poor.

At the time, many developing countries already had some form of Social Health Insurance scheme in place but where such schemes existed they provided protection mainly to civil servants and other formal sector workers.⁵⁴ Community Based Health Insurance schemes (CBHIs) were also put forward as potential

solutions for developing countries. CBHIs, frequently supported by international donors, were piloted and implemented in numerous developing countries, such as in Ghana, Senegal, and Kenya.⁵⁵ The perceived advantages of these programs were that in countries where government implementation was weak, local oversight of insurance schemes might improve the chances of success. However, such schemes remained small scale and did not provide coverage to large portions of the population, and the broader impact of these schemes on improving health service delivery was never well established.

The first President of Ghana after achieving independence from Britain was Kwame Nkrumah, who was a socialist and a populist. Under his leadership, which coincided with a period of relatively strong economic growth, the Nkrumah government put strong emphasis on expanding geographic coverage of health services to Ghanaians, including constructing health facilities in largely rural areas.⁵⁶ Health service expansion was rapid and basic health services were made free of charge to citizens.

However, during the 1970s the economic climate in Ghana changed dramatically with major declines in the price of important commodities, and the government began to suffer serious economic strain. Beginning in the mid-1970s, the government began to introduce new policies that gradually increased the level of cost-sharing by patients in public health facilities. International partners encouraged this process, even demanded it through the structural adjustment policies that aimed to lessen the burden on government for public services. In 1985, the Government of Ghana (GoG) introduced a system of user-fees to improve revenue generation at the facility level. Known informally as the “cash-and-carry” system, the user-fees introduced in Ghana generally represented very high levels of cost-recovery, covering both inpatient and outpatient health services as well as pharmaceuticals and other medical supplies.⁵⁷ While exemptions existed *de jure* in Ghana for certain populations, including those too poor to pay for health services, the *de facto* implementation of these exemptions was low.⁵⁸

Although user-fee policies remain in place today, the cash-and-carry system became and remains an unpopular policy in Ghana. During the 1990s, the focus of the health financing policies of the NDC government was to expand geographic coverage of health services and to improve the efficiency of health service delivery.⁵⁹ These policies include the further expansion of health facilities into rural areas and the separation of health stewardship and regulation from health service delivery through the creation of the Ghana Health Service in 1996. Despite these improvements, the proportion of the population accessing health services did not improve markedly. The lack of financial protection against user-fees was seen as a major barrier.⁶⁰

During the 1990s, the Ministry of Health (MoH) began a series of pilot studies to investigate the potential of CBHIs as a method of improving access to health services.⁶¹ It even created a dedicated unit within the MoH to further study such efforts. It was the NDC itself, which initially introduced this policy, who first began to make statements to address and reverse the policy on user-fees in 1997.⁶² However, despite this and the experiments that had been underway, the NDC did not introduce any formal policy to address the issue directly.

Capitalizing on the lack of inaction by the NDC, and recognizing the unpopularity of the cash-and-carry system, during the run-up to the 2000 election, the NPP promised to eliminate user-fees. While the NPP managed to secure a narrow victory over the NDC in 2000, it was not until the run-up to the following election in 2003 that the NPP fully elucidated its policy on user-fees. Initially it had put together a working group of largely technocrats with expertise in health system financing and health service delivery to develop the national health insurance policy that would replace user-fees. The group initially recommended continued expansion of existing CBHIs. Seeing these policies as too incremental and not distinctly different from the policies endorsed by the opposition party, the NPP rejected this proposal. It then dismissed the first working group and established a second working group to devise a new workable solution.⁶³ This committee was largely composed of political rather than technical experts, many of whom had been involved in the successful campaign in 2000 to unseat the NDC from power. This working group proposed a plan that outlined what was to become the NHIS today.⁶⁴

The original design of the NHIS included some features that were unconventional from a health policy and health systems financing perspective. First, rather than scale-up the program incrementally, the proposal was to scale-up the program rapidly with the target of achieving universal coverage of the population in just five years. Also, rather than covering particular diseases or target populations, the plan called for universal coverage and a benefits package that covered nearly the entire disease burden present in the country. Finally, rather than pricing the premiums for enrollment based on some actuarial models, the initial premium of GHC7.20, then approximately \$8USD, per person per year, was set in order to appeal to as broad of a sector of the population as possible, including those living in rural areas.⁶⁵

To finance the ambitious program, the NPP proposed expanding the VAT by 2.5 percentage points to become what is known as the NHIS levy. Formal sector workers, including members of the Social Security and National Insurance Trust, were also forced to enroll into the program, bringing along with them their payroll deductions. In essence, this financing model is a mixture of both social health insurance as well as tax-financed system, superficially with a dedicated new tax, a model that had not been tested in many other developing countries.

There was opposition to the original policy from both the formal labor sector, which ultimately were going to be forced to merge into this new scheme, as well as health care providers.⁶⁶ Despite protests and the NDC walking out of parliament during the discussion of the bill, the NPP pushed through legislation at the end of 2003 that laid the groundwork for the NHIS. According to statistics from the National Health Insurance Authority, by the end of 2010, there were over 8 million active subscribers to the NHIS, which represents roughly 34% of the entire Ghanaian population.⁶⁷ Coverage in the various regions in Ghana ranged from 23% in the Central Region to 53% in the Upper West Region. Although the program has yet to obtain universal coverage, these increases represent important increases in health insurance coverage in this country.

Although the NHIS was the most prominent health financing reform to have been implemented in Ghana, it was not the only one to have taken place

during this time period. Other prominent policy changes included the implementation of a free maternal health program in Ghana, which was first implemented in 2003 in four regions and subsequently rolled out to the rest of the country in 2005. The program was subject to a number of implementation challenges and was essentially made non-functional by the establishment of the NHIS.⁶⁸

Although discussions regarding the implementation of universal or national health insurance have been underway for well over a decade, such a program does not yet exist in Kenya. As early as 2001, then-President Moi announced an expansion of the program to cover all formal workers in addition to providing coverage to the poor.⁶⁹ However, it was not until 2004 that the Kenyan Parliament passed the National Social Health Insurance Fund (NSHIF) Bill in Parliament. The goals of this program were ambitious: to provide universal coverage of the entire Kenya population within nine years. The President, however, has yet to assent to this bill and has sent it back to Parliament for further debate due to concerns about the costs of the program.⁷⁰ Although renewed debate on the establishment of the NSHIF is expected soon in Kenya, no formal plan is yet in place to adopt such measures.

Some coverage of health insurance has existed in Kenya since nearly the time of Independence. The National Hospital Insurance Fund (NHIF) was passed by Parliament in 1966. The NHIF is mandatory for all civil servants and formal sector workers, and voluntary for informal workers and retirees. Voluntary premiums are 300 Ksh per enrollee per month (about \$3). Formal sector workers pay a share of their income, which can range from 150-2000 Ksh per enrollee per month (\$2-24).

The NHIF currently only covers inpatient costs at select government hospitals. Roughly 300 hospitals have contracts with the NHIF. The plan also covers the dependents of enrollees including children under the age of 18 and the spouse. As of 2010, roughly 2 million Kenyans contributed to the fund that then had roughly 8 million covered individuals.⁷¹ There are also limited private and CBHIs in Kenya but these schemes cover less than 1% of the total population.⁷²

In the absence of health insurance coverage, the main methods of health care financing include tax-based contributions from government and user-fees. Like many African countries, Kenya introduced a user-fee system in the late 1980s. The premiums were unpopular and were abolished in 1990, only to have them reinstated two years later due to lack of financing for the program.⁷³ In 2004, the Ministry of Health once again announced that user-fees would be free at dispensary and health center levels, but would require citizens to pay a small fee to register at these facilities. In 2004, user-fees at dispensaries and health centers were replaced with flat consultation fees of 10 Ksh (US\$0.13) and 20 Ksh (US\$0.26) respectively.⁷⁴ Despite these changes, inability to pay remains a major complaint among citizens in Kenya, suggesting that removal of these fees has been ineffective.

Efforts to improve health care financing and health service delivery in Kenya can perhaps more accurately be described as targeted to specific services and to specific populations. For example, starting in 2006 and with the support of the German Development Bank, the Ministry of Planning began to support a

pilot to provide vouchers for maternal health care and family planning in select districts in Kenya (Kitui, Kiambu, Kisumu, and parts of the slums of Nairobi). Despite being described as a pilot program, these pilots are still ongoing and have so far benefitted upwards of 120,000 people.⁷⁵ Additionally, in November 2008, the Government of Kenya launched a voluntary medical male circumcision program to expand access to male circumcision where the percentage of men who are circumcised is low and the prevalence of HIV is high. The government targeted Nyanza, Western, Rift Valley, and Nairobi provinces. A speech by Kenya's Prime Minister Raila Odinga (who hails from Nyanza province) was integral in support for the program.⁷⁶

Starting in the 1990s and under the auspices of the Bamako Initiative, Senegal also introduced a system of user-fees for health services. Small user-fees for primary care services were implemented at government health structures and higher fees were implemented for services delivered at secondary and tertiary facilities.⁷⁷ By the 2000s, financial constraints were seen as important barriers to the use of health services. Rather than adopting an across-the-board policy of eliminating or abolishing user-fees, starting in 2005 the government introduced a policy of free deliveries and caesarean sections (PFDC) to exempt pregnant women from user-fees for maternal health services. The PFDC was initially rolled out to 5 of the poorest regions in the country. The PFDC exempted all women from paying for normal deliveries taking place at health posts and health centers and for complicated births requiring cesarean sections at district and regional hospitals. The funding mechanism included the purchase of birth kits for facilities for normal deliveries and financial reimbursement to facilities for cesarean sections. Other complications were not covered. About a year later, the PFDC was rolled out to the remaining regions, with the exception of Dakar, which was never covered under this program. Although the PFDC has been generally believed to have led to small improvements in maternal health-seeking behavior, the program has not been without important implementation challenges.⁷⁸ The level of resources allocated to this program was seen as inadequate.

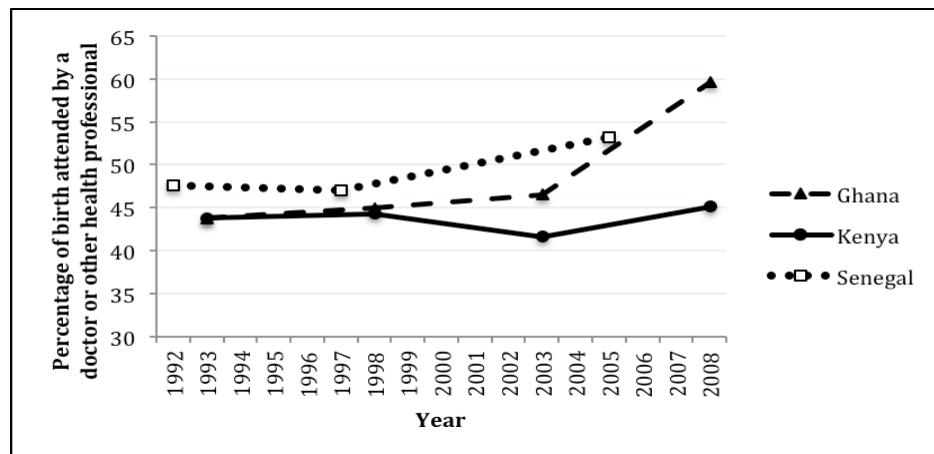
Senegal has also seen the development of numerous CBHIs. The first such scheme originated in the 1990s in the Western part of the country near the capital of Dakar.⁷⁹ While there has been substantial expansion of CBHIs throughout the country, there has yet to be any major efforts to organize or consolidate these schemes into a more national health insurance plans.

Comparison of health improvements

Given the divergent health financing reforms adopted by the countries of study, it is reasonable to expect that these health reforms might translate into different levels of improvement in health service utilization and in health outcomes. Using data from successive rounds of the DHS, we compared changes in common indicators of health service utilization and health outcomes in Ghana, Kenya and Senegal. All three countries have conducted at least three rounds of DHS since the early 1990s, allowing a comparison of trends in the utilization of services and health outcomes performance.

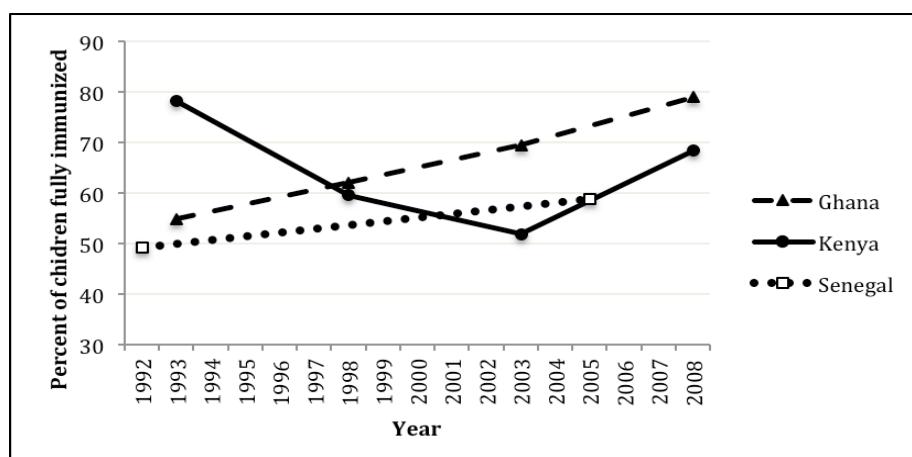
Figure 4 illustrates the trends in skilled birth attendance across the three studied countries. We see initially that skilled health professionals attended about half of all births during most of the 1990s in all three countries. However, by the mid-2000s the country trends diverge markedly with Ghana seeing a nearly 15-percentage point increase in skilled birth attendance between 2003 and 2008. Senegal saw a modest increase whereas Kenya's rates have remained nearly flat over the entire time period.

Figure 4: Skilled Birth Attendance in Ghana, Kenya, and Senegal 1992-2008



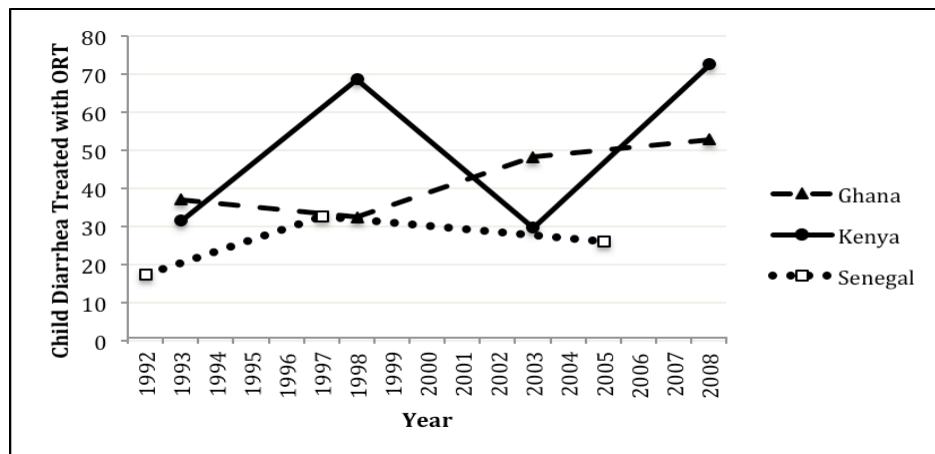
Trends in the proportion of children who received all recommended childhood vaccines are presented in Figure 5. In the 1990s, Kenya had much higher rates of coverage than either Ghana or Senegal but regressed in the early 2000s, seeing declines in coverage of nearly 30 percentage points. Immunization rates in Ghana and Senegal, however, were both increasing over this time period with Ghana achieving substantially higher overall rates by 2008. Immunization rates in Ghana increased nearly 30 percentage points over the available time period.

Figure 5: Child Immunization in Ghana, Kenya, and Senegal 1992-2008



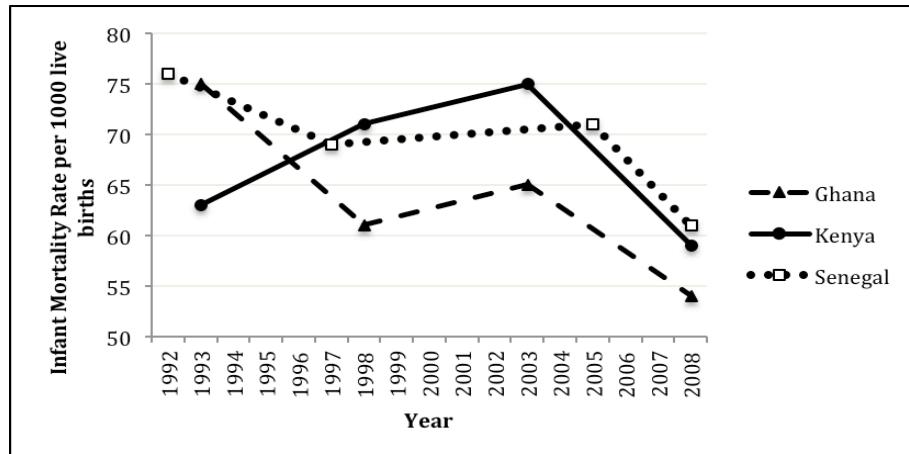
Among children who were reported to have diarrhea within the two weeks preceding the DHS, the proportion of children who reportedly received ORT are presented in Figure 6. While the reported trends in Kenya are erratic and highly variable over this time period, both Ghana and Senegal show modest increases in the proportion of children receiving treatment. Ghana shows the most overall improvement during this time period.

Figure 6: Child Diarrhea Treated with ORT in Ghana, Kenya, and Senegal 1992-2008



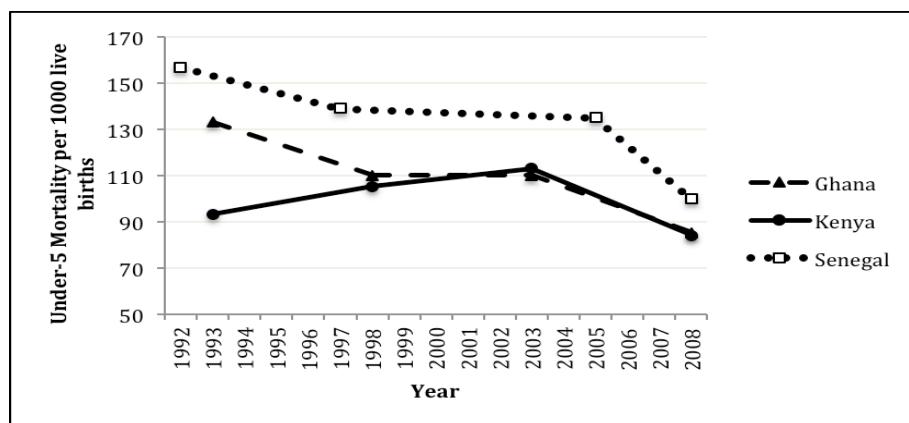
Finally, the impact of these changes in health services utilization on both the infant and under-five child mortality rates are presented in Figures 7 and 8. Although both Ghana and Senegal had much higher levels of infant mortality rates than Kenya during the beginning of the 1990s, both see significant declines in infant mortality over this time period, with Ghana performing slightly better than Senegal. Kenya actually sees increases in infant mortality over this time period before returning to levels slightly improved to those experienced nearly two decades earlier.

Figure 7: Infant Mortality Rate in Ghana, Kenya, and Senegal 1992-2008



We see similar trends when under-five mortality rates are compared in these three countries. Both Ghana and Senegal see gradual progress towards reducing child mortality over the investigated time period; Kenya sees declines in progress before once again catching up to levels seen nearly two decades earlier. Ghana sees the most impressive proportional decline in under-five mortality rates among the three countries investigated.

Figure 8: Under-Five Child Mortality Rate in Ghana, Kenya, and Senegal 1992-2008



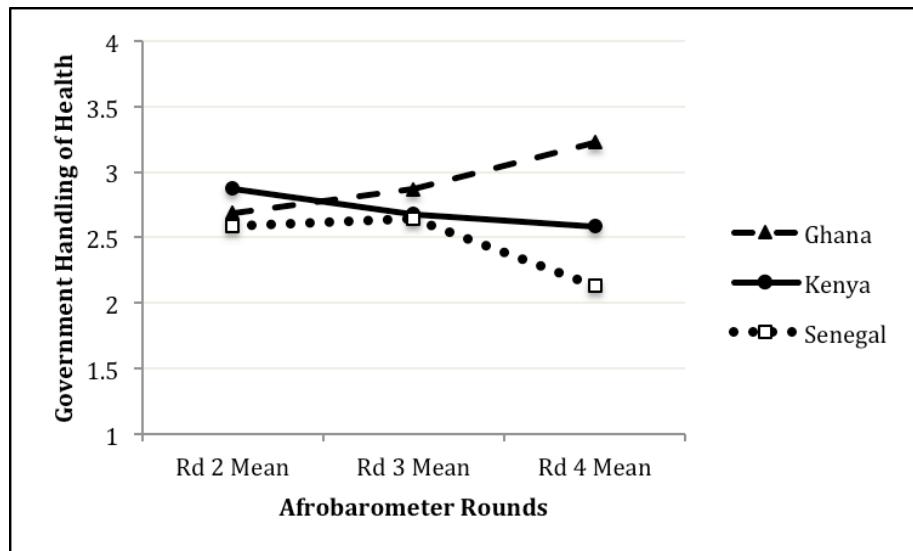
Comparing maternal and child health service utilization data as well as health outcomes in these three countries, Ghana appears to have made the most significant and consistent improvements over the past two decades. Although not all of these improvements can be directly attributable to changes in health system financing, given that there have also been significant changes in the economic performance and educational attainment in these countries over the same time period, there is evidence that the implementation of the NHIS has increased the utilization of health services and likely affected health outcomes directly.⁸⁰ For example, the biggest improvements in skilled birth attendance appear to coincide directly with the implementation of the NHIS in Ghana. The greatest proportional drop in infant mortality rates also appears to have coincided with the implementation of the NHIS.

Comparison of public satisfaction with health service delivery

Given the differences in health policy choice and subsequent health outcomes, we probed the Afrobarometer data for patterns on evaluations of government provision of health. In particular, we analyzed public opinion on the government's performance in improving basic health services. Using a 4-point scale ranging from 1 (very badly) to 4 (very well), Figure 9 illustrates a divergence in performance over time across the three countries. In Round 2 of Afrobarometer data collection, all three countries had an average score of 2.5-2.9. By Round 4, however, the average score given to government by ordinary Ghanaians has improved (mean 3.2), while the average score given to

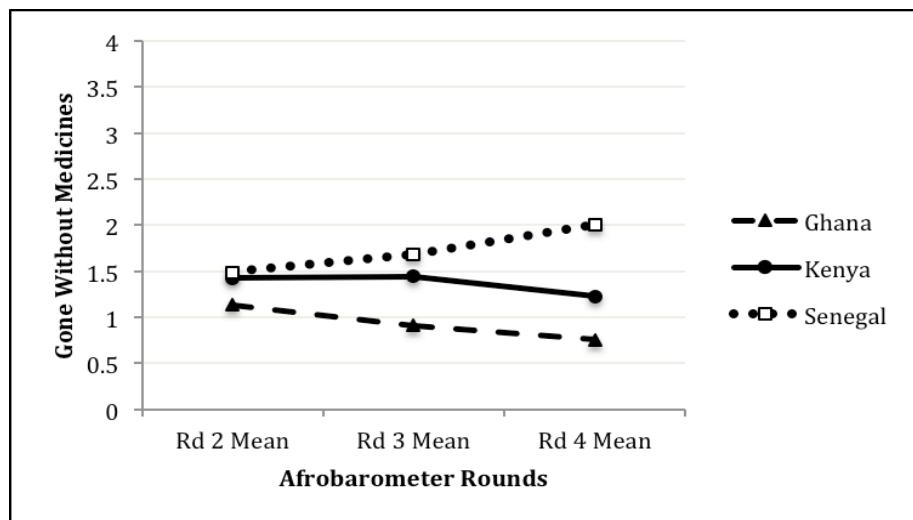
government by ordinary Kenyans and Senegalese has declined (means 2.1 and 2.6, respectively).

Figure 9: Evaluation of Government Performance on Improving Basic Health Services in Ghana, Kenya, and Senegal, Afrobarometer Rounds 2-4



A related Afrobarometer question shows a similar pattern, but perhaps with weaker substantive differences between countries. Respondents were asked whether they or anyone in their family had to go without medicines or medical treatment in the past year.⁸¹ This question is not explicitly about the government, but provides some illustration as to the constraints ordinary people have in accessing care. In a situation where governments provide wider, cheaper access to care, we might expect fewer respondents reporting having to go without care, which is consistent with the data: we find that fewer Ghanaians reported going without medicines or medical care in the previous year in all three rounds of Afrobarometer when compared to their counterparts in Kenya and Senegal (see Figure 10). The trend line declines in Ghana, meaning over time, fewer respondents reported going without medicines or medical care (Round 2 mean: 1.1; Round 3 mean: 0.9; Round 4 mean: 0.8). Senegalese reported going without medicine or medical treatment more frequently, and this increased over time (Round 2 mean: 1.5; Round 3 mean: 1.7; Round 4 mean: 2.0). Kenya held steady between Rounds 2 and 3 (means of 1.4), but the reports of going without medicine or medical care decreased in Round 4 (mean of 1.2).

Figure 10: Reports of Going Without Medicines or Medical Treatment in Past Year in Ghana, Kenya, and Senegal, Afrobarometer Rounds 2-4



DISCUSSION AND CONCLUSION

While the previous literature that has explored the link between democracy and health has suggested that more democratic countries tend to be healthier and provide better access to health services, there is little agreement on the exact mechanisms through which democratization leads to improved health outcomes. The findings of this paper suggest one potential mechanism: that countries where democratization has occurred, and specifically where these improvements in democracy have been perceived by citizens as giving them a voice and where electoral competition has put pressure on political parties, these countries are more likely to promise health policies that target a broader segment of the population. Comparing Ghana to Kenya and Senegal, two other countries which have also undergone democratization, but where there have been important differences in the extent to which these democratic changes have been perceived by regular citizens and have translated into electoral competition, we find that Ghana has adopted the most ambitious health reform strategy by designing and implementing the NHIS, seemingly against major challenges. We also find that Ghana experienced the greatest improvements in rates of skilled attendance at birth, increasing by nearly 15 percentage points since the introduction of the NHIS. Childhood immunizations also increased by nearly 30 percentage points, and there were improvements in the proportion of children with diarrhea treated by ORT. These changes in health service utilization also appear to have translated into changes in health outcomes: both infant and under-five mortality rates declined rapidly since the introduction of the NHIS in Ghana. These improvements in health and health service delivery have also been observed by citizens, with a greater proportion of Ghanaians reporting satisfaction with government handling of health service delivery relative to either Kenya or Senegal.

Our analysis is undergirded by an argument that the visibility of the provision of a benefit is what will generate support in the electorate, motivating a politician to choose such a policy if he wishes to gain or stay in office. We argued UHC is one such visible policy, however, there is another, fruitful lens through which UHC can be viewed: the distinction between provision and retrenchment. Policies of provision are popular, especially in developing countries where populations cannot typically afford to pay out-of-pocket for services. Retrenchment policies, on the other hand, would be rather unpopular for the same reason. We see these scenarios borne out in healthcare financing with the introduction of user fees during the structural adjustment period and also with the introduction of UHC in Ghana. Though provision and retrenchment seem to be opposing strategies, their enactment would not necessarily generate equivalently opposite reactions in the electorate if we consider the relevance of loss aversion, where losses hurt more than gains feel good.⁸² Future research could explore this distinction vis-à-vis the visibility hypothesis.

One methodological contribution of our study is a caution against using only a single measure of democracy to make comparisons across countries. We used the Polity 2 score to identify countries for our case selection, however, a closer examination of different indicators of democracy reveal a more varied democratic evolution in these countries. These other measures (public perception of democracy and electoral competition) appear to predict the adoption of more universal health policies and greater improvements in health indicators than the Polity 2 score.

Given our findings, how should we think about published scholarship that used Polity data to measure democracy in studies predicting health policies or evaluating health outcomes? Future research could reanalyze published studies that used Polity data⁸³ and substitute Polity measures with measures on election competitiveness and public attitudes toward democracy. The primary challenge would be amassing data, especially for cross-national studies. In addition, there may be other useful data measuring democracy (beyond electoral competition and public attitudes) that have yet to be identified as indicative of the mechanisms through which democracy impacts health.

Though our findings have potential implications for other government policy sectors (i.e., education), Kramon and Posner caution against too much generalization from the analysis of one public goods outcome given that governments have an array of public goods and services about which politicians can make different sets of choices that are still consistent with the overall goal to maintain power.⁸⁴ Future research could evaluate multiple universal policy choices to adjudicate whether our findings on the influence of perceived democracy and electoral competition on UHC choice in Ghana is consistent across sectors. Simply put, did Ghana also more aggressively pursue policies with universal benefits in education or electrification when compared to Kenya and Senegal?

Though this paper's contribution is primarily to the literature on how democracy can improve health outcomes, it raises questions for future research to investigate the relationship in the opposite direction: how does increasing access to care and subsequent improvement in health outcomes contribute to

democratic consolidation? Given our findings on evaluation of government health services, we took a preliminary look at Round 4 Afrobarometer data to assess whether evaluations of government provision of basic health services helps explain some of the variation in support for democracy. In each of the three countries studied here, but with a larger substantive effect in Ghana than in Kenya or Senegal, we found that more positive evaluations of government health care predict higher support for democracy (not shown). This is consistent with other scholarship that suggests that citizens of countries with higher levels of technical health service quality also have more trust in government.⁸⁵ Does the improvement of social services lead to greater demands for social services and the citizenry holding government accountable to those demands? If so, what are the mechanisms through which increased service provision leads to increased demand and accountability? Related to the aforementioned question about government substitution between different policy areas, does increased and improved provision of state-sponsored health care lead to a demand for increased and improved provision of other public goods and services, i.e., public education?

Given that developments in democracy occurred before the adoption of UHC in Ghana, our findings might also suggest that it might be necessary for institutional developments to occur prior to the adoption of effective health reforms. There is currently a strong movement among the global health policy community to advocate for more developing countries to move towards UHC coverage.⁸⁶ But such efforts might be inefficient or misguided if countries are unlikely to implement successful programs in the absence of strong democratic institutions. Instead, nationally led efforts to improve government might be more important for future health policy reforms than internationally led efforts to advocate for further expansions of such coverage.

We conclude with a discussion of the recent national elections in Ghana, Kenya, and Senegal. In Ghana, President John Atta Mills died in office in July 2012, just four months before the presidential election. Mills was succeeded in office and as the NDC candidate for president by his former Vice-President John Dramani Mahama, who narrowly beat out Nana Akufo-Addo from the NPP in the November 2012 election. The NPP has accused the NDC of tampering with the votes and while the election results stand, there has been an ongoing legal challenge of the election results. In Kenya, due to new constitutional rules, incumbent President Mwai Kibaki was unable to run in the election, however, his successor Uhuru Kenyatta was narrowly elected. The opposition party has also challenged the results of this election and there was some conflict in the lead up to the election, though not of the scale seen in 2007. In Senegal, the incumbent President, Abdoulaye Wade once again stood for President, after the Supreme Court deemed Wade's first term to have not counted, an action that led to significant protests in the run up to the election (Senegal's constitution states a two-term limit for Presidents). Although Wade was leading after the first round of voting, Wade lost the election to Macky Sall in the second round and then accepted the outcome of the election leading to the first turnover in power in Senegal in over 30 years.

While it is too soon to know what the outcomes of these elections will mean for the future of UHC in these countries, the argument we set forth in this

paper would suggest the increased democratic competition in Senegal will likely lead to a greater number of citizens there having positive opinions about the nature of democracy and will put pressure on the government to adopt more universal policies due to the increased competition. Going forward, we might see movement towards more universal health policies in Senegal than we have seen in the past. Indeed, since the 2012 election, the Ministry of Health of Senegal has begun to speak publicly about implementing UHC and has even released a preliminary study and action plan to do so. In Kenya, the newly elected President announced plans to exempt pregnant women from users fees but is also exploring the idea of also implementing a voucher program to continue to target poor rural women. In Ghana the NDC has yet to implement the one-time premium and earlier this year, the Christian Health Association of Ghana threatened to pull out of the scheme altogether, citing the non-payment of medical bills by government. Clearly the democratization process in all of these countries has been a complicated and not always linear process, but the timing of improvements in the nature of the democratic process does appear to be connected to the adoption of more universal health policies, providing evidence of a mechanism that can explain the relationship between more democratic governments and improved health outcomes.

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¹ David Lake and Matthew Baum, "The Invisible Hand of Democracy: Political Control and the Provision of Public Services," *Comparative Political Studies* 34, no. 6 (2001): 587-621; Jeroen Klomp and Jakob de Haan, "Is the Political System Really Related to Health?" *Social Science & Medicine* 69, no. 1 (2009): 36-46; Thomas Zweifel and Patricia Navia, "Democracy, Dictatorship, and Infant Mortality," *Journal of Democracy* 11, no. 2 (2000): 99-114. Timothy Besley and Masayuki Kudamatsu, "Health and Democracy," *American Economic Review* 96, no. 2 (2006): 313-318. Alvaro Franco, Carlos Alvarez-Dardet, and Maria Teresa Ruiz, "Effect of democracy on health: ecological study," *BMJ* 329 (2004): 1421; Hazem Adam Ghobarah, Paul Huth, and Bruce Russett, "Comparative Public Health: The Political Economy of Human Misery and Well-Being," *International Studies Quarterly* 48, no. 1 (2004): 73-94.

² David Stasavage, "Democracy and Education Spending in Africa," *American Journal of Political Science* 49, no. 2 (2005): 343-358; David Stasavage, "The role of democracy in Uganda's move to universal primary education," *Journal of Modern African Studies* 43, no. 1 (2005): 53-73; David Brown and Ahmed Mushfiq Mobarak, "The Transforming Power of Democracy: Regime Type and the Distribution of Electricity," *American Political Science Review* 103, no. 2 (2009): 193-213.

³ David Lake and Matthew Baum, "The Invisible Hand of Democracy: Political Control and the Provision of Public Services."

⁴ David Brown and Wendy Hunter, "Democracy and Human Capital Formation: Education Spending in Latin America, 1980 to 1997," *Comparative Political Studies* 37, no. 7 (2004): 842-864.

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⁶ David Lake and Matthew Baum, "The Invisible Hand of Democracy"; Jeroen Klomp and Jakob de Haan, "Is the Political System Really Related to Health?"

⁷ Thomas Zweifel and Patricia Navia, "Democracy, Dictatorship, and Infant Mortality."

⁸ Timo Besley and Masayuki Kudamatsu, "Health and Democracy."

⁹ Alvaro Franco, Carlos Alvarez-Dardet, and Maria Teresa Ruiz, "Effect of democracy on health: ecological study."

¹⁰ Hazem Adam Ghobarah, Paul Huth, and Bruce Russett, "Comparative Public Health: The Political Economy of Human Misery and Well-Being."

¹¹ Michael Ross, "Is Democracy Good for the Poor?" *American Journal of Political Science* 50, no. 4 (2006): 860-874.

¹² David Stasavage, "Democracy and Education Spending in Africa"; David Stasavage, "The role of democracy in Uganda's move to universal primary education."

¹³ Robin Harding and David Stasavage, "What Democracy Does (and Doesn't) Do for Basic Services: School Fees, School Inputs, and African Elections," unpublished working paper, NYU (2012).

¹⁴ David Brown and Ahmed Mushfiq Mobarak, "The Transforming Power of Democracy: Regime Type and the Distribution of Electricity."

¹⁵ David Mayhew, *Congress: The Electoral Connection*, New Haven, CT: Yale University Press (1974); Bruce Bueno de Mesquita, Alastair Smith, Randolph M. Siverson and James D. Morrow, *The Logic of Political Survival*, Cambridge, MA: MIT Press (2003).

¹⁶ For a thorough theoretical treatment of this argument in comparing "visible" public good provision of democratic vs. non-democratic regimes, see Anandi Mani and Sharun Mukand, "Democracy, visibility and public good provision," *Journal of Development Economics* 83 (2007): 506-529.

¹⁷ Here we highlight policy visibility, but another useful distinction is between policies that increase provision of goods and services and policies that retrench provision of goods and services. The different policy strategies would have opposite, though not likely equivalent, effects on potential voters.

¹⁸ Robin Harding and David Stasavage, "What Democracy Does (and Doesn't) Do for Basic Services."

¹⁹ Giovanni Carbone, "Democratic Demands and Social Policies."

²⁰ Raphaël Franck and Ilia Rainer, "Does the Leader's Ethnicity Matter? Ethnic Favoritism, Education and Health in Sub-Saharan Africa," *American Political Science Review* 106, no. 2 (2012): 294-325.

²¹ We chose Polity over other frequently used democracy indices first because it measures democracy on a continuous, rather than dichotomous, scale. Alternatively, the Democracy-Dictatorship dataset uses a stark dichotomous classification. During this period, African countries were undergoing democratic change and we wanted a measure that would help us select countries moving along at a similar pace. Freedom House data has also been used by scholars as a continuous measure of democracy, but such an approach with Freedom House data is particularly ill-advised. José Cheibub, Jennifer Gandhi, and James Vreeland, "Democracy and dictatorship revisited," *Public Choice* 143 (2010): 67-101.

²² The Afrobarometer is a comparative series of national public attitude surveys conducted in 20 African countries. Ghana is the only country in our study represented in Round 1, collected in 1999. All three cases – Ghana, Kenya, and Senegal – are represented in data collection during Afrobarometer Rounds 2 (2002-2003), 3 (2005), and 4 (2008).

²³ Afrobarometer, 2009 [electronic datafiles: 1999-2008], Ann Arbor, MI: Inter-university Consortium for Political and Social Research. Available at: <http://www.afrobarometer.org>.

²⁴ The question wording was: "Overall, how satisfied are you with the way democracy works in [country name]?" with the following potential responses: [Country] is not a democracy, Not at All Satisfied, Not Very Satisfied, Fairly Satisfied, and Very Satisfied. Missing data and don't know responses are not included in the foregoing analysis.

²⁵ The question wording was: "In your opinion how much of a democracy is [your country] today?" with the following potential responses: Not a democracy, A democracy, with major problems, A democracy, but with minor problems, and A full democracy. Missing data, don't

know responses, and respondents reporting to not understand the question are not included in our analyses.

²⁶ The question wording was: “How well or badly would you say the current government is handling the following matters, or haven’t you heard enough about them to say: Improving basic health services?” Potential responses included: Very Badly, Fairly Badly, Fairly Well, and Very Well. Missing data and don’t know responses are not included in the foregoing analysis.

²⁷ Gallup World Poll, [electronic data file], retrieved from the Gallup WorldView database on April 25, 2012 at: <https://worldview.gallup.com/>.

²⁸ The question asked, “In this country, do you have confidence in national government?”

²⁹ The question asked, “Is corruption widespread throughout the government in this country, or not?”

³⁰ The question was part of a series and asked, “In this country, do you have confidence in each of the following, or not? How about honesty of elections?”

³¹ Demographic and Health Surveys have been conducted in many low and middle-income countries since the mid to late 1980s. Not all low and middle-income countries have conducted a DHS but some have conducted repeated surveys, usually at intervals of 3-6 years. Data is collected from reproductive aged women, their households, and their children. Health utilization data has been collected for children born within 3 or 5 years of the survey. The choice of 3 or 5 years is country specific, but is nearly 5 years in all countries.

³² Lindsay Whitfield, “Change for a Better Ghana’: Party Competition, Institutionalization and Alternation in Ghana’s 2008 Elections,” *African Affairs* 108, no. 433: 631-641.

³³ Lindsay Whitfield, “Change for a Better Ghana”.

³⁴ Kevin Fridy, “The Elephant, Umbrella, and Quarrelling Cocks: Disaggregating Partisanship in Ghana’s Fourth Republic,” *African Affairs* 106, no. 423 (2007): 281-305; Lindsay Whitfield, “Change for a Better Ghana”.

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³⁷ Stefan Dercon and Roxana Gutiérrez-Romero, “Triggers and Characteristics of the 2007 Kenyan Electoral Violence,” *World Development* 40, no. 4 (2012): 731-744.

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⁴² Macky Sall was formerly with the PDS but formed his own party (the APR) in December 2008 following his removal by Wade as the President of the National Assembly in November 2008.

⁴³ Dennis Galvan, “Democracy without Ethnic Conflict: Embedded Parties, Transcendent Social Capital & Non-violent Pluralism in Senegal and Indonesia,” Paper presented at the annual meeting of the American Political Science Association, San Francisco, CA, September 2001.

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International Development and Conflict Management, University of Maryland. Available at: <http://www.systemicpeace.org/polity/Senegal2010.pdf>.

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The Future of Universal Health Coverage: A Philippine Perspective

Ramon Pedro P. Paterno

The present Philippine administration has committed to achieve Universal Coverage by 2016. Yet the Philippines has relied on Social Health Insurance or PhilHealth as the key to its health financing reform. PhilHealth has been attempting to achieve UHC along the classical “contributory” model in the face of an increasing informal sector, and is experiencing great difficulties in achieving universal population, benefit, cost and utilization coverage. This paper examines governance, both global and national, within and outside the health system, which has hindered the achievement of universal coverage. The Philippines’ continued adherence to a neo-liberal economic development model, its reliance on PhilHealth, and PhilHealth’s insistence on a “contributory scheme” have all contributed to the protracted journey towards universal coverage. Developing countries should reassert the original principles of Alma-Ata Primary Health Care Declaration which called for socio-economic development within a new International Economic Order to achieve health equity and health for all.

INTRODUCTION

“Health is a fundamental human right; that the existing gross inequality in health status of the people, between developed and developing countries and within them, is unacceptable; that economic and social development, based on a New International Economic Order, is of basic importance to the attainment of health for all (or universal coverage), and to the reduction of the health disparities among and within nations.” The world has the necessary resources needed to achieve health for all but “a considerable part... is now spent on armaments and military conflicts.” Thus, with those few phrases, the 1978 Alma Ata Primary Health Care Declaration had capsulized, in broad strokes, the root causes of health inequities, poverty, and underdevelopment; and the needed solution to achieve health for all.

Presently, the World Health Organization (WHO) asserts that the path to universal coverage can be financed either through taxes or Social Health Insurance premiums, or a combination of both.¹ The recent contrasting experience of two ASEAN countries, the Philippines (negative) and Thailand (positive), may hold lessons for the path to Universal Health Coverage (UHC). Although rapid achievement of universal population coverage is very enticing, it represents only the first step and will not be enough to achieve Universal Coverage and the ultimate goal of lessening health inequities. Deeper issues must be examined, particularly those pertaining to governance issues, both at the global and national level, within and outside the health system, and within the health system, design and implementation issues of the Universal Coverage program, be it tax or premium based, or a combination of both. Globally, we need to examine not only WHO health policies but also that of the World Bank and other financial institutions which have gained prominence in terms of Global Health Policy. Again it will be necessary not to confine ourselves to health policy but also to include economic and

political policies, which may have a much larger effect on the improvement of health and the attainment of health equity.

METHODOLOGY

A systematic search of PubMed, ProQuest Central, Science Direct and Wiley Online databases was done. Search items included "PhilHealth" "Social Health Insurance Philippines", "Universal Coverage," "PhilHealth enrollment," "PhilHealth Support Value," and "PhilHealth utilization." Searches had no date restrictions. As part of the tri-agency PhilHealth Validation team, from 2006-2008, the author compiled literature on PhilHealth from PhilHealth's file of commissioned studies including their Annual Reports, Stats, and Charts, as well as presentations to Local Chief Executives, and the DOH's file on PhilHealth researches, including unpublished studies. The author also conducted key informant interviews of PhilHealth officials at the senior level and conducted field visits of three PhilHealth regional offices, one each in Luzon, Visayas and Mindanao, including the Autonomous Region of Muslim Mindanao (ARMM).

CONTEXT:

The Philippines is considered a lower middle-income country. In 2010, GDP was \$199.5B with a population of 93.2 million, and a per capita GDP of US\$2,140.² In 2009, service industry share was 55.1% of GDP, with industry share at 29.9% and agriculture share at 14.9%. Agriculture remains a major economic activity with manufacturing on the decline over the last two decades. Remittances from overseas Filipino workers are a major source of national income, comprising about 13.4% of GDP in 2009.³

The Philippines was a former colony of the United States and its economic, political, and health systems were closely patterned and linked with the United States. In the economic field, from 1909 to 1946, when the Philippines was still a colony of the United States of America, a series of laws established "free trade" between the United States and the Philippines: the Payne-Aldrich Act during the colonial period, the Bell Trade Act of 1946, extending free trade until 1954, thereafter, tariffs would be increased until its full amount in 1974. In exchange for the release of war damage payments from the United States, the Philippines had to amend its constitution with the Parity Amendment, giving US citizens equal rights with Filipino citizens in land ownership, exploitation of natural resources and operation of public utilities. In 1955, the Laurel-Langley Agreement extended the provisions of free trade to 1974, thus perpetuating the neocolonial nature of the Philippine economy.

In health, the Department of Health (DOH) was carved out of the colonial Health and Public Welfare Bureau. The 1954 Rural Health Act established a nationwide network of Rural Health Units based in the municipalities (towns) and city health centers in the cities.

Direct health provision and governance was centralized in the Department of Health, with its Regional, Provincial, and Municipal Health Offices. In 1978, the Philippines was one of the signatories of the Alma Ata Primary Health Care Declaration, and Primary Health Care and Health for All by 2000 became national health policy. This policy was gradually replaced by various versions of "selective Primary Health Care" following global health trends, such as the implementation of "GOBI" or growth

monitoring, oral rehydration, breast feeding and immunization" as health interventions meant to decrease child mortality without needing to address social inequities. In 1991, with the passage of the Local Government Code, health service provision was devolved to the local government units: provincial, city and municipal government units (local government units or LGUs)

In a decentralized setup, the DOH serves as the lead governing agency, with both local government units (LGUs) and the private sector providing services to the population. The DOH provides national policy direction and develops national health plans, technical standards, and guidelines. The DOH has also retained management of tertiary hospitals such as national specialty hospitals and regional hospitals, and Metropolitan Manila district hospitals. It provides guidance to the regions through its regional offices called Centers for Health and Development, providing technical assistance, medicines, and supplies for LGUs to implement in their areas, national health programs such as the Expanded Program of Immunization, control of leprosy, schistosomiasis, filariasis, rabies, malaria, tuberculosis, HIV/AIDS, dengue, and emerging and re-emerging diseases such as SARS, and avian influenza.⁴ Under the Local Government Code of 1991, provision of health services was devolved to the local government units: the hospitals, (provincial and district), to the provincial government, and the public health and primary care services to the municipal government. The City Health Offices manage both hospital and public health services within the city.⁵ Implementation of the national public health programs became the responsibility of the LGUs.

The Philippine health system has a very large, highly unregulated private sector; 70% of physicians are in private practice, private clinics or hospitals, serving the population that can afford to pay from out of pocket or from private health insurance with the remaining 30% as government physicians employed by the DOH in its retained hospitals or by the local government units, serving the rest of the population with low incomes who go to government health facilities.⁶ ((The latest Family Income and Expenditure Survey (FIES 2009)⁷ had the lowest 30% of households with negative savings at the end of the year, with the 5th decile having only P10,479 (\$240 at P43.50:\$1) savings at the end of the year, not even enough for an appendectomy.))

The minimal regulatory function is exercised by the governmental Professional Regulatory Commission, which licenses the physicians, by the DOH, which licenses the health facilities, and by PhilHealth which accredits both the physicians and the health facilities. Only PhilHealth accredited physicians and health facilities can avail of reimbursements from PhilHealth for services rendered.

The attainment of Universal Health Care or Universal Coverage is therefore dependent on the availability and accessibility of health facilities and services provided by the primarily tax financed DOH, and the LGUs, which are financed by a combination of taxes, PhilHealth reimbursements and out-of-pocket payments; and the private sector, financed by out of pocket payments and PhilHealth reimbursements. PhilHealth, as a government owned and controlled corporation manages the National Health Insurance Program, the social health insurance program of the Philippines.

Access has always been problematic in spite of the physical presence of a nationwide network of health facilities from the village "barangay health stations" to municipal (town) and city health centers, and the network of public hospitals from the district, provincial, regional, and national levels, and the network of private clinics and

hospitals. According to the DOH National Objectives for Health 2005-2010, only 35% of deaths were attended by health professionals in the year 2000.⁸ What is perhaps more important is to disaggregate access according to income groups. The National Demographic and Health Survey (NDHS) 2008 found that: 83.9% of mothers from the richest quintile delivered in a health facility, and 77% were delivered by a doctor; in contrast 86.8% of mothers from the lowest quintile delivered at home, and 71% were delivered by a *hilot* or traditional birth attendant. The NDHS 2008 asked women respondents to rank their problems in accessing health care. The women in the poorest quintile ranked their problems thus, in order of priority: getting money for treatment, no drugs available, distance to health facility, having to take transport, no provider available, not wanting to go alone (the need for a watcher means another person taken away from economic production), no female provider available, and getting permission to go for treatment. For all income groups, the three top ranked problems were: getting money for treatment, concerned that no drugs were available, and concerned that no provider was available.⁹

In 1969, the Philippine Medical Care Act was passed and Medicare, as it was eventually called, was implemented in August 1971. The health insurance program provided hospital benefits for the formally employed government sector. The private formally employed sector had health benefits from the Social Security System.

In 1995, Republic Act 7875 established the National Health Insurance Program (NHIP), the country's social health insurance program, and PhilHealth, as the corporation which managed the Social Health Insurance program. PhilHealth is a government owned and controlled corporation, and is an attached agency of the Department of Health. Its mandate was to "provide all citizens of the Philippines with the mechanism to gain financial access to health services." It was supposed to achieve universal coverage in 15 years or by 2010.¹⁰

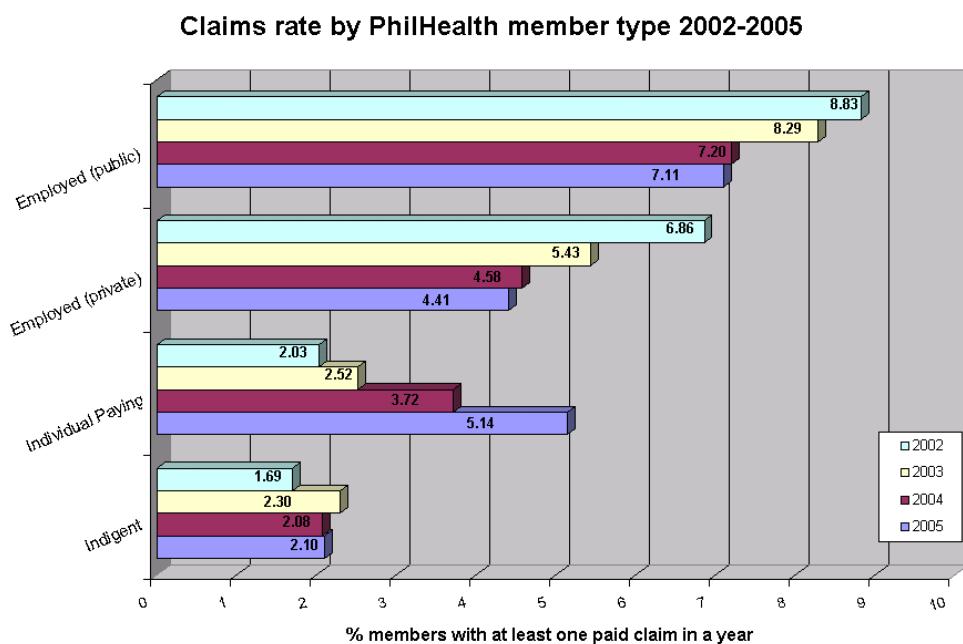
PhilHealth assumed the administration of the former Medicare program from the Government Service Insurance System in 1997, and the health benefits fund for the private formal sector from the Social Security System in 1998, and thus became the single payer for Social Health Insurance.¹¹ (It assumed the administration of the health funds of the Overseas Workers Welfare Administration in 2005).

It was the flagship program of the past administration, and in 2005, PhilHealth's president claimed "unprecedented achievements that most sectors brand as 'too good to be true'..." PhilHealth's news release then claimed that due to "the wide extent of information and education campaigns targeting various sectors of the populace, PhilHealth posted an increase in total membership ... from 37.4 M in 2001 to 69.5 M in 2004 or an increase of about 89%."¹² PhilHealth claimed to have achieved 83% coverage by end of 2004, very close to its self-defined universal population coverage of 85%. PhilHealth's success story was being echoed in the international arena, with studies, such as that by Obermann and Jowett which concluded in a 2006 article that: "social health insurance in the Philippines has been a success story so far and provides lessons for countries in similar situation."¹³

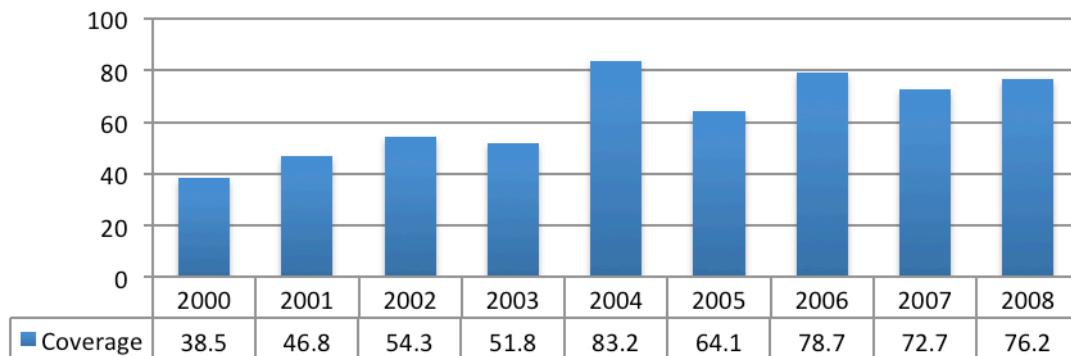
In 2005, Republic Act 9241 amended the PhilHealth Law and in its oversight provision, mandated the National Economic and Development Authority (NEDA) together with the National Statistics Office and the National Institutes of Health of the University of the Philippines Manila (UPM-NIH) to conduct validation studies of PhilHealth performance. The validation studies found that PhilHealth's claimed

population coverage was bloated with double countings, (double counting referred to both working spouses being counted as distinct PhilHealth members and therefore counted as two separate households covered rather than one single household). PhilHealth would not be able to achieve its 85% coverage by 2007, much less sustain it after that; that its benefits were not comprehensive and were mainly inpatient benefits; that its financial protection was only from 30-50% of total hospitalization costs and significantly, the Sponsored beneficiaries were utilizing their PhilHealth benefits less compared to the other PhilHealth member groups, or social solidarity in reverse.¹⁴ PhilHealth reported claims rates or percent of members with at least one paid claim in a year among its different member groups. For the years 2002-2005, the sponsored members consistently had a much lower claims rate (average of 2.04%), while the formally employed government sector had the highest rate, though it decreased through the years (average 7.86%). It is followed by the formally employed private sector, which also shows decreasing trend (average 5.32%). The claims rate of the Individually Paying members steadily increased reaching a high of 5.14% of members with at least one paid claim during the year (average 3.35%), thus, reflecting the trend towards adverse selection. (See Figure 1)¹⁵

Figure 1: Claims Rate by PhilHealth member type 2002-2005



Source: Adapted from a presentation by Matthew Jowett, Eduardo Banzon, Reuben John Basa, "The Impact of Social Health Insurance in the Philippines 1972 – 2007" as cited in Validation of PhilHealth Performance using 10 Key Performance Areas for the years 2004-2006.

Figure 2: PhilHealth's population coverage 2000 - 2008

Source: Data from Romualdez et al., 2011 p. 44

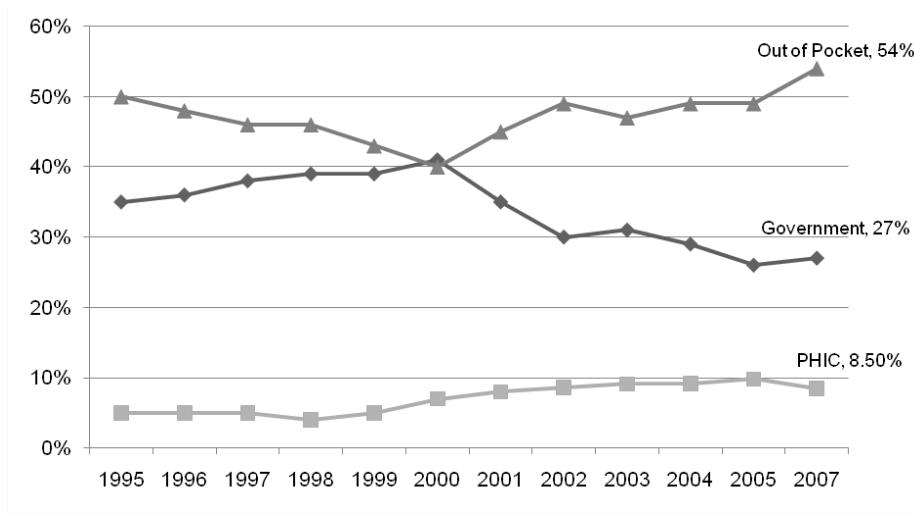
Figure 2 shows the population coverage of PhilHealth which for many years hovered around 50% population coverage, then shot up to 83% in 2004 (an election year and PhilHealth membership cards were given out during the election campaign), then dramatically dropped in 2005.¹⁶ (The local government units had not budgeted their premium counterpart so that the PhilHealth cards given out in 2004 expired after one year).

In 2008, the National Demographic Health Survey (NDHS) covering almost 14,000 households, came out with the result that only 38% of Filipino households had at least one PhilHealth member. (PhilHealth coverage is by household). The wide discrepancy in population coverage as claimed by PhilHealth can be explained by the fact that PhilHealth's claim is an estimate and not based on actual count of its members. PhilHealth's information system has been described by a vice president of PhilHealth as "being islands of good databases that do not talk to each other." Hence, PhilHealth is forced to estimate the number of its members based on its collection database. Each estimated member is considered a head of the household, and a multiplier is applied to come up with the population covered. (Each member group, the formal sector, the informal sector, and the sponsored members have their own multipliers representing the group's average household size). What happens is that a household may have two members, e.g., if both husband and wife are working, and by this method, they are each counted as a separate household. PhilHealth's method of estimating its population coverage therefore has a lot of double counting errors, as explained previously. PhilHealth is now in the process of improving its information system and promises to do an actual count based on its membership database.

From 2001, various health sector reform efforts, the DOH's Health Sector Reform Agenda (2001), the National Objectives for Health (NOH) 2005-2010, Formula One and now the DOH Health Care Financing Strategy 2010-2020, have looked at PhilHealth as having the key role in health financing reform: "health care reforms will focus on making the National Health Insurance Program (PhilHealth) the major payer of health services (HSRA), the flagship program of health financing (NOH) and "the lead implementer of health financing reform." (Formula One) Figure 3, however, clearly shows government share (40%) of THE decreasing steadily from the year 2000 to only 27% in 2007, with PhilHealth share slowly increasing only to 8.5%, with a resultant out-

of-pocket share of 54%. Dr Alberto Romualdez, DOH secretary during this time, said in an interview, that PhilHealth would indeed have been the key to health financing, if government share had been maintained at 40% and PhilHealth share had risen to 30%, thus decreasing OOP share to less than 30%.

Figure 3. Government, PhilHealth and Out of Pocket %share in Total Health Expenditure



Source: National Health Accounts, 2007

The DOH Health Care Financing Strategy 2010-2020 recognizes that UHC will be financed by both taxes and PhilHealth premiums but it asserts that “the small share of government spending relative to GDP, approximately 19.0% in 2009, shows the limitation of mobilizing additional resources out of tax-based money.” The policy is further elaborated thus: “The most important goal is to reduce OOP expenditure ... to 35% (of THE) in 2020. Considering the limitations of the government budget, extra-budgetary resources from PhilHealth have the greatest potential to supplant OOP with prepaid funds (underscore ours).” The author disagrees with this analysis, and in another study showed that with political will, the Philippine government can create fiscal space to finance UHC, and even bring down OOP to 20% share of THE. The Philippine government can achieve this by increasing its tax collection rate to 17% of GDP from its present rate of 14% of GDP. Historically, the Philippine government was able to achieve a tax collection rate of 17% GDP in 1997 under then President Fidel V. Ramos.¹⁷ The 3% of GDP additional tax revenue would amount to about P300-400B, (\$6-\$9B), enough to finance UHC by 2015.

“Expand coverage, increase benefit payments, include outpatient benefits, use alternative forms of payment mechanisms, improve marketing to increase beneficiary knowledge about PHIC benefits, and improve information system” has been the mantra since 2001 and is now being echoed by the present political administration as the Aquino Health Agenda. Yet coverage, in all its dimensions, remains problematic: 38% population coverage,¹⁸ mainly in-patient benefit package, and low financial protection. In its 2011 Annual Report, the DOH claimed PhilHealth population coverage had increased to 82% again¹⁹ but the significance of this 82% population coverage is belied

by PhilHealth's persistent, very low share in Total Health Expenditure (THE). (See Figure 3 for National Health Accounts up to 2007²⁰). The latest National Health Accounts data showed PhilHealth's share at 9.1% in 2011 with out-of-pocket share at 52.7%.²¹

WHY WAS PHILHEALTH NOT ACHIEVING ITS MANDATE?

To attempt to answer the above question, the author used the principles contained in the 1978 Alma Ata Primary Health Care Declaration, which also contained the social determinants to health approach. The Alma Ata Declaration reaffirmed that health is a fundamental human right; that the existing gross inequality in health status of the people, between developed and developing countries and within them, is unacceptable; that economic and social development, based on a New International Economic Order, is of basic importance to the attainment of health for all (or universal coverage), and to the reduction of the health disparities among and within nations. Social determinants to health approach is about improving health and decreasing health inequities by tackling the root causes of disease and health inequalities. The most powerful of these causes are the social conditions in which people live and work, referred to as the social determinants of health (SDH).²² Wilkinson and Marmot assert that "while medical care can prolong survival and improve prognosis after some serious diseases, more important for the health of the population as a whole are the social and economic conditions that make people ill and in need of medical care in the first place. Nevertheless, universal access to medical care is clearly one of the social determinants of health."²³

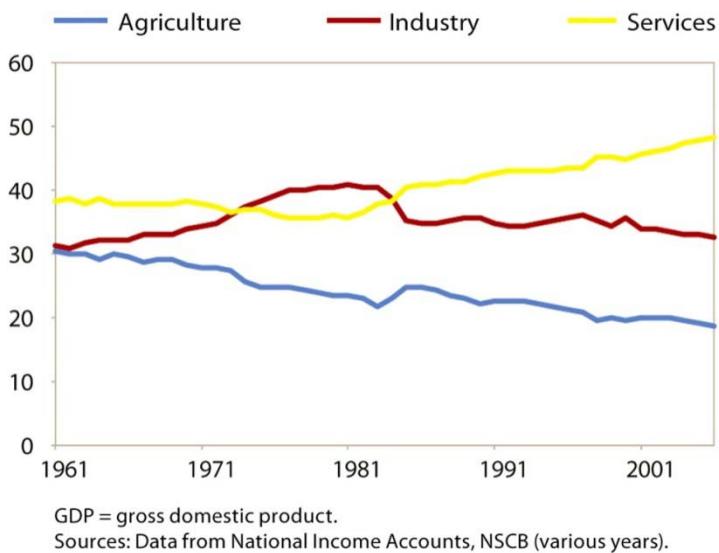
GOVERNANCE ISSUES THAT HAVE DIRECTLY OR INDIRECTLY AFFECTED HEALTH IN THE PHILIPPINES:

Economic Development Policy

As mentioned above, in the 1950's, a World Bank report described, that within Asia, the Philippine economy was second only to that of Japan. Two Philippine presidents, Elpidio Quirino (1948-1953), and Carlos P. Garcia (1957-1961) pursued nationalist economic policies such as the import substitution strategy of development and the Filipino First policy or Buy Filipino, both meant to spur the development of the manufacturing sector. From 1962 onwards, the next Philippine President, Diosdado Macapagal, upon advice of the World Bank and the International Monetary Fund, instituted decontrol of the flow of foreign capital and the devaluation of the Philippine peso. In September 1972, President Ferdinand Marcos declared Martial Law. There was a convergence of interest between Marcos and the US government: Marcos was prevented from running for a third term, and the Laurel Langley agreement, which established "Parity Rights" for American citizens, was about to lapse in 1974. Thus the United States provided tacit approval for the declaration of Martial Law. Vice President George Bush even toasted Marcos for his "adherence to democratic principles." Martial Law saw the development of "Crony Capitalism" or Marcos cronies controlling big business. Foreign debt ballooned, and provided another instrument by which the Philippines had to follow WB-IMF Structural Adjustment Programs.

Since the 1980s, after Martial law, the Philippines had followed what is called a neo liberal development paradigm with succeeding administrations carrying out more or less similar economic policies within that Neo-liberal framework: liberalized trade and investments, lowered tariffs on imports, wage suppression for global competitiveness, privatization, reduced government intervention, and business deregulation. Liberalized global trade was supposed to lead to national growth and development. Neo Liberal economic technocrats gained ascendancy in reaction to the “state cronyism” of the Martial Law regime from 1970 – 1986. The objective was for Philippine industries to become more competitive and eventually for the Philippines to join the newly industrializing countries: Singapore, Malaysia, Thailand, and Indonesia.²⁴ The government’s role was limited to ensuring the unfettered play of market forces, establishing the infrastructure, and maintaining an equal playing field for both local and foreign investors. The Philippines because of its massive debt, largely incurred again during the Martial law years had to agree to a series of conditionalities, called Structural Adjustment Program, to be able to continue to avail of loans from the World Bank and IMF. Essentially this consisted of addressing the country’s fiscal deficit, managing balance of payments, reducing government spending, mostly for social services and currency devaluation, with the end goal of paying for the national debts incurred. In health, this meant lowered government health expenditure, introduction of user fees, fiscal autonomy for government hospitals for income retention, and safety nets in the form of social health insurance. (See Figure 3, with continued marked decrease of government share in THE from the year 2000.)

Figure 4: Decreasing industry sector share in GDP



Source: ADB, 2007

Each succeeding administration did indeed achieve growth, President Corazon Aquino with an average of 3.9%, President Fidel Ramos with 3.8%, President Joseph Estrada with 2.4%, and President Gloria Macapagal Arroyo, the highest with an average of 4.5%, but all were “non-inclusive” growth. The impact on the economy can be seen from a

2007 Asian Development Bank study which showed both industrial and agricultural share in the GDP steadily decreasing, with the service sector share steadily increasing (see Figure 4) .²⁵ The industrial casualties included manufacturers of textiles, paper products, ceramics, rubber products, furniture, petrochemicals, beverages, shoes, and leather goods. While the goal was to make the Philippines a “newly industrializing country” by the year 2000, the opposite had happened. The country was “de-industrializing.” The WHO Commission on Social Determinants to Health explains the mechanism for the de-industrializing effect:

...World Trade Organization (WTO) agreements already in place or under negotiations will restrict the ability of developing countries to pursue policies that favour domestic producers and industries with the potential for rapid growth. Such development policies were routinely used by today's high-income countries during the process of industrialization and successful late-industrializers adopted economic policies that involved a high level of state planning, including policy instruments at least some of which would not be allowed under current WTO rules... ”²⁶

Erik Reinert, a historical economist, asserts in his book, *How Rich Countries Got Rich and Why Poor Countries Stay Poor*, that countries able to industrialize, become rich, and that countries that remain agricultural, remain poor. Countries that were able to industrialize did so with government intervention, providing protection of their fledgling industries.²⁷ Developing countries were not allowed to use these instruments to develop their industries under the neo-liberal economic paradigm. In addition to “de-industrialization”, the Philippines, originally a food exporting country, became a food importing country from the mid-1990s onwards.

The impact of “de-industrialization” is a decrease of the formal sector and an increase of the informal sector, making PhilHealth coverage of the informal sector increasingly difficult if it is through the classic enrollment mechanism.

SAPs affect health in two ways: by cutting down on availability of health services (through health budget cuts), and the demand for health services (by reducing household income), thus families have less money for health. This happens because growth that results is not inclusive growth.²⁸

Global Health Governance

In 1978, the Philippines was one of the signatories of the Alma Ata Declaration of Primary Health Care which asserted that to address health inequities, “economic and social development based on a New International Economic Order is of basic importance to the fullest attainment of health for all”. Yet, after merely a few years, UNICEF came out with what has been called Selective Primary Health Care in the form of specific health interventions (the so-called GOBI or Growth monitoring, Oral rehydration, Breast feeding, and Immunizations) which can be cost effectively implemented and would have dramatic impact on lowering infant and child mortality. Selective Primary Health Care was supposed to be a temporary solution to the more comprehensive and radical Alma Ata Primary Health Care.²⁹

The background paper for the WHO Commission On Social Determinants of Health described the role of WHO during this period:

The late 1980s and early 1990s witnessed a waning of WHO's authority, with de facto leadership in global health seen to shift from WHO to the World Bank. In part this was a result of the Bank's vastly greater financial resources; by 1990, Bank lending in the population and health sector had surpassed WHO's total budget. In part the shift also reflected the Bank's elaboration of a comprehensive health policy framework that increasingly set the terms of international debate, even for its opponents. While open to criticism in many respects, the Bank's health policy model as presented in the 1993 World Development Report *Investing in Health* showed intellectual strength and was coherent with regnant economic and political orthodoxy.³⁰

The World Development Report 1993 *Investing in Health*³¹ came out with a clear acknowledgement of WHO as a "full partner ...at every step of the preparation of the Report." The three key messages of the WB's *Investing in Health* were: 1). Foster an environment that enables households to improve health, 2). Improve government spending on health, and 3). Promote diversity and competition (WB).

Recommendations for fostering an environment that enables households to improve health included pursuing economic growth policies that benefit the poor, expanding investment in schooling, particularly for girls, and promoting rights of women through political and economic empowerment. Ironically, while calling for the implementation of economic growth policies that benefit the poor, the WB's Structural Adjustment Policy was leading to economic growth in the Philippines that did not benefit the poor. This failure is succinctly capsulized by the presentation of the Philippine's NEDA Director General of the newest Philippine Development Plan 2011-2016, which included the question: "Why is inclusive growth so elusive?" The World Bank country representative, in his closing statement in the Philippine Development Forum last February 2011, also recognized this continuing non-inclusive growth of the Philippines, saying: "They (development partners) also expressed concerns about the fact that the poverty situation has not improved despite the growth acceleration over the last decade...."³²

Recommendations for improving government spending on health include reducing spending on tertiary facilities, specialist training and interventions that are not cost effective; financing a package of public health interventions surrounding infectious disease control, prevention of AIDS, environmental pollution, and risky behaviors; financing and ensuring delivery of a package of essential clinical services; and improving management of government health services through decentralization of administrative and budgetary authority and contracting out of services. Targeting is mentioned with regards to the provision of essential clinical services with the phrase "at least to the poor".

Recommendations for promoting diversity and competition include: government spending for public health and essential health package; other remaining services to be financed privately or by social insurance (underscore ours). Diversity and competition in provision of health services and insurance can be promoted by encouraging social or private insurance for clinical services outside of the essential package, encouraging suppliers to compete to provide inputs, (domestic suppliers should not be protected from international competition), to address information asymmetry, disseminate information on provider performance, on drugs and equipment, and on accreditation of facilities and providers.

Promote diversity and competition was another way of saying privatize health services outside of public health and the essential health package, with insurance, both private and social, as one major component. In fact, Table 7.1 of the WB Report, re-labels “Promote diversity and competition” as “Facilitate involvement by the private sector.”

In contrast to the social determinants approach, the WB document asserts, “increased scientific knowledge has accounted for much of the dramatic improvement in health that has occurred in this century”, citing smallpox eradication and reflecting a biomedical paradigm for addressing health inequities. The tacit premise also of the WB document is that government resources are limited, that is why the private sector must be involved.

The law (RA 7875)³³ that established social health insurance in the Philippines mandated PhilHealth to “provide all citizens with the mechanism to gain financial access to health services, in combination with other government health programs.” Highest priority was given to “coverage of ALL with at least a basic minimum package of health insurance benefits.”

The PhilHealth law reflected the guidelines set forth in the WB 1993 document. It makes a distinction between Public Health Services and Personal Health Services and states:

“The Government shall be responsible for providing public health services for all groups such as women, children, indigenous people, displaced communities in environmentally endangered areas, while the Program (PhilHealth) shall focus on the provision of personal health services.”

This echoes the WB recommendation: government to cut down on spending for tertiary, specialist care, and focus on spending for public health services and essential health services, leaving the financing of the other health services to private financing, private insurance and social health insurance. Until recently, this has guided PhilHealth in its benefit package formulation, concentrating on inpatient benefits, with a few outpatient benefit packages, such as TB DOTS. Outpatient benefits included health consultation and limited diagnostic laboratories in accredited government health centers, which were mostly free to begin with.

In its guiding principles, the law reiterates a Philippine constitutional provision which contains the targeting provision for PhilHealth:

“...the State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. Priority for the needs of the underprivileged, sick, elderly, disabled, women, and children shall be recognized. Likewise, it shall be the policy of the State to provide free medical care to paupers.”

Unfortunately, the Philippines has limited technical capacity in identifying the poor. Identification depends on a means test, which tries to classify families based on proxy indicators for family income. The information system is not developed enough to document family income. PhilHealth attempts at identifying the poor families for their Sponsored programs depended on the LGUs identifying the poor and because local politics were dominated by political patronage, the Sponsored program in the past was plagued with what PhilHealth officers called “the political poor” or those selected for their support for the incumbent local chief executive. The Sponsored program was

plagued with exclusion of the true poor and inclusion of the non-poor.³⁴ This assessment is echoed by the DOH Health Care Financing Strategy monograph, which states: "...deficient targeting tools might have led to non-poor households that are being subsidized, while a big number of poor households have been excluded."³⁵

GOVERNANCE OF THE PHILIPPINE HEALTH SYSTEM

As mentioned above, the Department of Health is the lead agency of the health sector in the Philippines. Before the devolution in 1991, the DOH headed a centralized three-tiered health organization: tertiary hospitals at the national and regional levels; provincial and district hospitals; and city and municipal health centers including village health centers. After devolution, governance became fragmented: cities and municipalities were in charge of providing basic health services including promotion and preventive services; provinces were in charge of provincial and district hospitals and the DOH was in charge of national health governance and the direct supervision of retained tertiary regional hospitals and national specialty hospitals. PhilHealth was in charge of running the National Health Insurance Program.

PhilHealth is a government owned and controlled corporation that is an attached agency of the Department of Health. Although the Secretary of Health sits as the Chairperson of the Board of PhilHealth, PhilHealth, as a government corporation, had substantial autonomy in organizing its offices, in setting premium rates, designing benefits, accreditation of health care providers and determining the mechanisms for paying them.³⁶ Often times, PhilHealth would drag its feet when it came to benefit package formulation, especially if it was perceived to lead to a decrease in PhilHealth's reserve fund. There was also a recognized problem of "who pays for what services" between the DOH and PhilHealth.³⁷

The president of PhilHealth is appointed by the President of the Philippines. PhilHealth has had 6 presidents: the first two were not public health doctors, nor administrators. The first was a legal officer of the Department of Health and the second was an actuary of a commercial insurance company. PhilHealth has a board, which sets the overall policy and strategic directions of the SHI program. On paper, the board represents all the sectors of Philippine society: local government, social welfare and development, the National Anti-Poverty Commission, Civil Service Commission, Government Social Insurance System, the social security system for private employees, the labor sector, employers, overseas Filipinos, self-employed, and health care providers; but the directors are the head officers of these government agencies or their representatives. There are no direct representatives of people's organizations such as trade unions, farmers associations, consumer groups or PhilHealth beneficiaries to provide feedback to the board.

The major achievement of PhilHealth was having established itself as a national organization, with 17 regional offices and 106 local offices, with the national office able to manage billions of pesos as the country's single social health insurance payer. In 2010, it collected P30 billion (\$694 Million) in premiums and reimbursed P30.5B (\$701 million) as benefit payments. This was the first time PhilHealth's reimbursements exceeded its premium collection since 1995.³⁸

Its major weakness had been its commercial insurance orientation in terms of benefit package formulation, and build-up and protection of its reserve funds. Former senior government officials have critiqued the PhilHealth board and its president in an interview in March 2011 as being “afraid to spend the PhilHealth reserves, ‘that’s why it is often called an HMO (health maintenance organization) or commercial health insurance.”³⁹ Its reserve at that time was P110 Billion (\$2 Billion USD) when the Department of Health’s annual budget was less than P30 Billion (\$689 Million USD).

DESIGN AND IMPLEMENTATION ISSUES THAT HINDER UNIVERSAL HEALTH CARE

PhilHealth is a social health insurance, following the principle of social solidarity. As the social health insurance program of the Philippines, it is the sole payer.

Membership and enrolment

Although the Philippine constitution recognizes health as a right, entitlement to PhilHealth benefits is dependent on PhilHealth’s capacity to enroll the potential member. PhilHealth has the following member groups: the formally employed private sector, the formally employed government sector, the informal sector under the Individually Paying Program, the indigents enrolled in the sponsored program, the retirees who have been paid up members for at least 10 years, enrolled in the Non-Paying Program, and as a recent addition, the overseas Filipino workers.

PhilHealth employs a “premium contributory system” as a requirement for membership. The formal sector is automatically enrolled by their employer whether private or government. Premiums at 2.5% of their month salary are automatically deducted, equally shared by employer and employee, and remitted to PhilHealth. PhilHealth applies a salary cap on computing the monthly premium; the latest salary cap as of 2013 is P35,000 (\$805) monthly income. The salary cap means that a person

earning more than P35,000 (\$805) per month will be paying the same amount in premiums as someone earning P35,000 (\$805). Above the salary cap, premium contribution becomes regressive. PhilHealth has so far refused to remove the salary cap in premium contribution.

Enrollment for the Sponsored member previously depended on the LGU’s identification of those qualified to be sponsored, i.e., those classified as the poorest of the poor based on a means test. Because Philippine politics is characterized by political patronage, sponsored members included what PhilHealth officers refer to as the “political poor” or those granted PhilHealth membership cards in exchange for their loyalty and support. LGUs’ sponsored members more often than not included non-poor while excluding some true poor. Enrollment is also dependent on the local government’s willingness to budget their counterpart premium share.⁴⁰

The present revitalized PhilHealth program⁴¹ attempts to remedy this by: identifying the sponsored members through the National Household Targeting system implemented by the Department of Social Welfare and Development, for its Conditional Cash Transfer program. Beneficiaries under this Conditional Cash Transfer program are automatically enrolled in the PhilHealth sponsored program and their premiums are fully subsidized by the national government from taxes, to obviate non-enrollment because of lack of LGU premium counterpart. Reports however are already coming in

from interviews of Municipal Health Center physicians of similar deficiencies again in this household targeting system (inclusion of non-poor and exclusion of true poor).

Although by law, PhilHealth membership is compulsory, in implementation, membership of the informal sector is voluntary. The informal sector must contribute P200 a month (about \$4.50) to be a member. Since their income was irregular, it was difficult to enroll and collect their premiums regularly. PhilHealth initially tried to enroll the informal sector through its PhilHealth Organized Groups Interface (POGI) with limited success because of the generally unorganized nature of the informal sector (estimates of the informal sector range from 40 – 70% of the workforce, and they are made up of farmers, street vendors, tricycle drivers, jeepney drivers, and small neighborhood store owners. The informal sector also includes self-employed professionals like doctors and lawyers.) POGI gave way to Kasapi or PhilHealth's attempt at enrolling the informal sector, this time, through microfinance groups with at least 1000 members, again with limited success as seen from their struggle to achieve universal population coverage. The plan now is to make PhilHealth membership compulsory by requiring proof of PhilHealth membership a requirement for all government transactions. So tricycle and jeepney drivers will have to show their PhilHealth membership card when they renew their licenses. The same will be true when small neighborhood stores will renew their business permit. However the problem remains in identifying the non-professional informal sector or the near poor from the professional informal sector. The LGUs will partially subsidize the premiums of the near poor, while the professional informal sector will have to pay premiums based on their income. Segmentation of the informal sector between the professionals and non-professionals for differential premiums will again entail additional administrative expense. Reports are coming in that there is substantial overlap between the sponsored members subsidized by the National Government, and the sponsored members identified and subsidized by the local government units, again compounding estimation of population coverage.

Benefits Package Formulation

Member benefits are mainly in-patient. In-patient benefits are uniform for all member groups and cover room and board charges; professional fees; laboratory charges; charges for use of hospital facilities and equipment, and prescription drugs. Emergency and transfer services are also included but are not well publicized.

The formulation of PhilHealth benefits has not been based on burden of disease studies (for one, Philippine burden of disease studies have so far been limited to a few conditions), but have been: 1). Benefits inherited from the previous Philippine Medicare program and 2). products of lobby efforts of various interest groups. For example, PhilHealth has delayed coming out with an outpatient anti-hypertension benefit package, in spite of hypertension being associated with many of the top ten causes of mortalities in the Philippines. It has instead come out with a newborn package that includes newborn screening for metabolic disorders (the most common disorder G6PD had an incidence rate of 1.9% of those screened while the next one, congenital hypothyroidism had an incidence of 0.03%.)⁴²

Some packages reflect a commercial health insurance orientation. For example, PhilHealth continues to point out that it has an inpatient SARS package of P50,000 (\$1,150) in spite of the many years that have passed since the last case of SARS.

There are limited outpatient benefits, which presently include outpatient consults, limited laboratory exams, and limited prescription drugs in accredited government health centers for Sponsored members. Other outpatient benefits for all members include Directly Observed Treatment Short course for TB, and antenatal and post-natal checkups included in the maternity package. PhilHealth has been studying an out-patient benefit package that would include medicines for hypertension and diabetes, two co-morbidities of leading causes of mortality.

Payment Mechanisms

PhilHealth reimburses providers primarily through a fee-for-service payment mechanism, which incentivizes providers towards overprovision of services. To remedy this, PhilHealth is in the process of moving to case payments, and later on, to case mix DRG based payments. At present, it only has 23 cases under the case payment mechanism but projects to cover all cases by the end of 2013. PhilHealth is slowly expanding its case payment mechanisms to cover more cases and will also be implementing a true capitation payment mechanism for outpatient benefits targeted initially for Sponsored members.

Financial Protection

Estimates of PhilHealth's financial protection range from 30-50% of hospitalization costs, depending on the severity of illness, with lower percentage for the more serious illnesses. One of the major reasons for this is its First Peso design with low ceiling benefits, with balance billing allowed. This means PhilHealth pays for the first peso of hospital confinement up to the set ceiling benefits. The hospital or the provider is allowed to charge the patient for the balance of the bill. If, for example, the patient's hospital bill reached P100,000 (\$2,300) and PhilHealth covers the first P40,000, (\$920) the patient still has to pay the balance of P60,000 (\$1,380) to the provider. In this setup, PhilHealth transfers the financial risk to the patient. Gertler and Solon in 2002⁴³ showed that when PhilHealth raises its ceiling benefits without reforming its first peso coverage and with balance billing allowed, hospitals just raise their fees, with private hospitals capturing 100% of the increase in ceiling benefits and government hospitals capturing 70%. Providers still pass on the same balance to the patient. Increases in PhilHealth ceiling benefits therefore will not provide the member with increased financial protection but will increase the income of the providers and lead to higher health care costs.

These design problems have been largely recognized by DOH and the new PhilHealth administration. The large PhilHealth reserve fund will be mobilized to increase PhilHealth reimbursements and therefore increase PhilHealth's share in total health expenditures. DOH is implementing a policy of zero co-payment, no balance billing for all Sponsored members confined in government hospitals admitted for one of the 23 cases defined for case payment. However, even with the projected increase in

PhilHealth reimbursements and the shift to case payments, PhilHealth's share in the Total Health Expenditure will most likely increase to only 20% of THE⁴⁴.

In summary, PhilHealth is having problems achieving Universal coverage in its breadth, depth and height dimensions for the following reasons: 1). Breadth or universal population coverage: the persistent poverty incidence, which necessitates identification of the poor and subsidy of their premiums; and the increasing number of the informal sector within a "de-industrializing" economy; 2). Comprehensiveness of benefits – the orientation set by the World Bank's *Investing in Health* model wherein the DOH spends for public health and essential health package, and PhilHealth concentrates on other health services, and a persistent commercial health insurance mindset, which delayed the development of outpatient benefits including outpatient medicines, and 3). Height of financial protection – the first peso coverage, with low ceiling benefits, with balance billing allowed, the slow shift to case payment mechanisms and resistance by the private sector to this shift. The future of Universal Coverage in the Philippines would require:

In the short term

Integration of national health governance among the different stakeholders in the health sector, primarily between the DOH and PhilHealth in the implementation of Universal Coverage or *Kalusugan Pangkalahatan*. DOH should be the lead agency, together with the other major stakeholders in health, to map out the direction and implementation of Universal Health Care. The distinction between revenues raised for the health sector whether from general taxes or from SHI premiums should blur. Revenues whether from taxes or from SHI premiums should be considered revenues for the whole health sector and should be allocated in the most efficient manner: essentially a primary care based Universal Health Care. (UHC should go beyond insurance coverage.)

A clear articulation of the health policy of addressing health inequities through Universal Health Care, accepted by the major stakeholders.⁴⁵ Health inequities among income groups must be included in the monitoring indicators for Universal Health Care. Addressing health inequities must be considered in the formulation of benefit packages and the priority areas for implementation of UHC.

A quantum increase in government spending for health to bring down the OOP share to 20 - 30% of Total Health Expenditures (THE).⁴⁶ PhilHealth's share in total health expenditure will most likely only reach 20% of THE,⁴⁸ necessitating government share, both national and local, to increase to 50 - 60% of THE. Health financing is a necessary but not sufficient component for Universal Health Care; but we cannot even talk of Universal Health Care if financing is insufficient for both public health and personal care.

Automatic coverage of the rest of the population outside of the formal sector. The Philippines has much to learn from Thailand in its rapid achievement of universal population coverage. In contrast to the Philippines' difficult and complicated path to Universal population coverage, Thailand's experience has been more rapid and straight forward. Thailand retained its insurance schemes for the private employees (SSS), and for government employees and dependents (CSBMS), and decided to cover the rest of the population through a tax financed universal coverage scheme. (UCS).⁴⁷ In less than 10 years, Thailand has been able to reduce Out of Pocket expenditure to less than 20%.⁴⁸

Accelerated development by PhilHealth of comprehensive benefit packages (outpatient and inpatient) that will benefit first, its sponsored beneficiaries and eventually all Filipinos. Global budget for tertiary hospital benefits and contractual capitation for outpatient and secondary hospital benefits should be the way to go in terms of payment mechanisms.

In the long term:

The Social Determinants approach to health: A review of the Philippines' national economic development paradigm to ensure inclusive growth in the light of the country's experience with the Neo-liberal economic development framework which had not led to industrialization and inclusive growth. It must also be recognized that the Structural Adjustment Program had affected the achievement of Universal Health Care by drastically reducing government expenditure on health and depressing household income. Industrialization must be a strategic part of the Philippine Development Plan.

The National Economic and Development Authority (NEDA) in its "The Philippine Midterm Progress Report on the MDGs 2007, prescribed an anti-poverty strategy that "must focus on agriculture and rural development through asset reforms (agrarian reform, urban land reform and ancestral domain reform) accompanied by reforms in the agricultural center, such as investments in productivity improvements and supporting infrastructure." By implementing a genuine land reform, the Philippines will create a domestic market of about a 100 million population, with money to buy products manufactured by local industries. Manufacturing can initially start with producing farm support equipment such as water pumps and handheld tractors and eventually diversify to non-agricultural products. Such a program for national industrialization would be a departure from the neo-liberal economic development paradigm.

It might be well worth the time for a developing country like the Philippines, to examine the Cuban paradox^{49,50} for the paradox consists of two achievements: firstly, that a small, low income country was able to attain a health status comparable to that of richer developed countries and secondly, that Cuba was able to achieve economic development and address social and health inequities outside of the Neo-liberal economic framework.

Finally, in the arena of global health governance, WHO must boldly reassert its moral leadership on global health policy and review all global health policies through the lens of health as a fundamental human right and not health as an investment for Global trade and "trickle down" development.

The future of Universal Health Coverage still has to be: back to the original message of Alma Ata Primary Health Care: that "health is a fundamental human right", that "the existing gross inequality in health status of the people between the developed and developing countries as well as within them – is politically, socially and economically unacceptable ..." that "economic and social development based on a New International Economic Order is of basic importance to the fullest attainment of health for all"; that "governments have a responsibility for the health of their people,...", that "an acceptable level of health for all the people of the world ... can be attained through a fuller and better use of the world's resources..."⁵¹

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Fee Exemption for Maternal Care in Sub-Saharan Africa: A Review of 11 Countries and Lessons for the Region

Fabienne Richard, Matthieu Antony, Sophie Witter, Allison Kelley, Isidore Sieleunou, Yamba Kafando, and Bruno Meessen

Several countries have recently introduced maternal health care fee exemptions as a quick win approach to reach MDG 5 goals. It has also been argued that these policies were relevant first steps towards universal health coverage (UHC). The scope and contents of the benefits package covered by these policies vary widely. First evaluations raised questions about efficiency and equity. This article offers a more comprehensive view of these maternal health fee exemptions in Africa. We document the contents and the financing of 11 of these policies. Our analysis highlights (1) the importance of balancing different risks when a service is the target of the policy – C-sections address some of the main catastrophic costs, but do not necessarily address the main health risks to women, and (2) the necessity of embedding such exemptions in a national framework to avoid further health financing fragmentation and to reach UHC.

INTRODUCTION

In recent years, African countries have experienced a strong political dynamic to improve financial access to public health service.¹⁻³ In the early 2000s, user fee exemption policies were initiated for specific pathologies (HIV, malaria, and tuberculosis) or priority groups of people (pregnant women, children under five). There is growing evidence that user fee removal is a strategy that can improve service utilization.⁴⁻⁵ A large number of countries have put in place maternal health fee exemptions as a quick win approach to reach the Millennium Development Goal (MDG) 5 (maternal mortality reduction).⁶ While such initiatives can be seen as real opportunities to accelerate progress towards UHC both at the national and the global level,⁷ they also raise specific challenges.⁸ The scope and content of the benefits package covered by these policies seems to vary widely, with some countries covering Caesarean sections only, while others aim to cover a more comprehensive set of maternal health services – it is not clear whether selection of services was based on expert maternal health advice. There is also evidence that user fee removals are often driven by political objectives with insufficient consultation of technical experts, i.e. while political ownership at the national level is strong, technical governance is inadequate.⁹ Available evidence on the impact of these policies raises some questions about efficiency and equity.¹⁰⁻¹³ In the context of limited resources, the financing and sustainability of these policies also poses a challenge.¹⁴ These are matters of concern for technicians and health care providers managing the daily implementation of these exemption policies in the field.¹⁵⁻¹⁶

This article aims at gathering a more comprehensive view on these maternal health fee exemptions in Africa. We document the contents and the financing of 11 of these policies and discuss the lessons that arise. We identify the main challenges faced

by these policies, a few governance issues and perspectives in terms of their possible contribution to UHC.

Background

In May 2009, some international agencies¹ met in the framework of Harmonization for Health in Africa (HHA) and agreed on better coordination of their efforts in managing knowledge and their support to health systems and health policy. A community of practice (CoP) strategy was adopted.¹⁷ The driving idea behind this strategy is to promote and capitalize on the knowledge and experience of the African experts. In November 2010, HHA agencies, with some 15 African countries, jointly agreed to establish a CoP² on the issue of financial access to health services (FAHSCOP).

The first CoP-organized technical workshop on the topic of maternal fee exemptions was held in Bamako in November 2011. The workshop addressed operational issues and brought together 70 people working on the issue of maternal health and its financing from more than 10 African countries: national experts from Ministries of Health, maternal health care providers, researchers, civil society representatives, and partners working on the topic, as well as members of the CoP. Six Francophone countries (Benin, Burkina Faso, Mali, Morocco, Niger, and Senegal) and four Anglophone countries (Ghana, Kenya, Nigeria, and Sierra Leone) were represented. The selection of countries was based on (1) the existence of an on-going national maternal health fee exemption policy, (2) a balance between French and English countries, and (3) available financial support for the participation of technicians, researchers, and civil society representatives. To prepare for the workshop, questionnaires were sent to all the participating countries (11 countries) to compare the benefits package and the funding modalities of these fee exemption policies. The objective of this article is to present a comparative analysis of country policies, based on these questionnaires. While there have been many studies of individual country policies in the past, this analysis provides a more comprehensive understanding of the scale, scope, and approach of current maternal fee exemption policies across the continent.

METHODS

A key principle of CoPs is to favour co-development of knowledge. This study relied on such a participatory approach, as it is practitioners – and more specifically cadres in charge of the policies under study – who provided the data and validated them.

Data Collection

A questionnaire was developed by health economists and maternal health researchers and validated by the workshop organizing committee. The questionnaire had two purposes: to establish the contents of the benefits package covered, as well as its funding modalities. A pre-test was done in Burkina Faso, working with the person in charge of the national subsidy for deliveries and emergency obstetrical and neonatal care. In September 2011, questionnaires were sent to the key informants in the 11 countries (key informants were people in charge of monitoring the policies). Where information was lacking, researchers who had studied these policies in the countries helped to fill in the

questionnaires. Follow-up with key informants was done by telephone and email. Completed questionnaires were reviewed by experts in the field to identify any inconsistencies; if needed, further clarification was sought from the country.

Data Analysis

Country data were entered and analysed with Excel. Benefits packages were compared across the World Health Organization's (WHO) three dimensions of universal coverage: population, services, and costs coverage.¹⁸ Individual country analyses and the comparative tables were reviewed and validated by country key informants during the CoP Bamako workshop.

In order to make the international comparisons easier we have converted local currencies using Purchasing Power Parities (PPPs).³

Study Limitations

The sample was not comprehensive, as we did not include all sub-Saharan African countries that have introduced a maternal health fee exemption policy. Only countries attending the workshop were asked to complete the questionnaire. Eleven countries completed the questionnaire, but only ten attended the Bamako workshop (the Burundi delegation was not able to come).

As researchers were unable to go to the field to collect the data, the questionnaire was sent by email to key informants. Part one of the questionnaire regarding the composition of the benefits package covered by the policy was generally completed, but there were some gaps in the information provided in part two on the policies' financing. All financial information was collected for 2010 with the exception of Mali, Niger, and Nigeria. For Niger, data were provided for 2009, while the data for Nigeria on the policy costs cover the period from November 2008 to June 2010. For Mali, no financial information was obtained via the questionnaire. The data for Mali comes from the 2011 USAID evaluation report.¹⁹ The information on the total cost of the exemption policy was not available in Ghana and Senegal.⁴ It was not possible to obtain data about the total amount of external funding used to support the exemption policy in Sierra Leone. External funding was done via budget support (to the national budget) and thus an estimate of the total amount of development funds used to indirectly support the programme was not possible.

More generally, there are limitations inherent in a one-off cross sectional survey, particularly in describing policies that are dynamic and embedded in changing health systems.

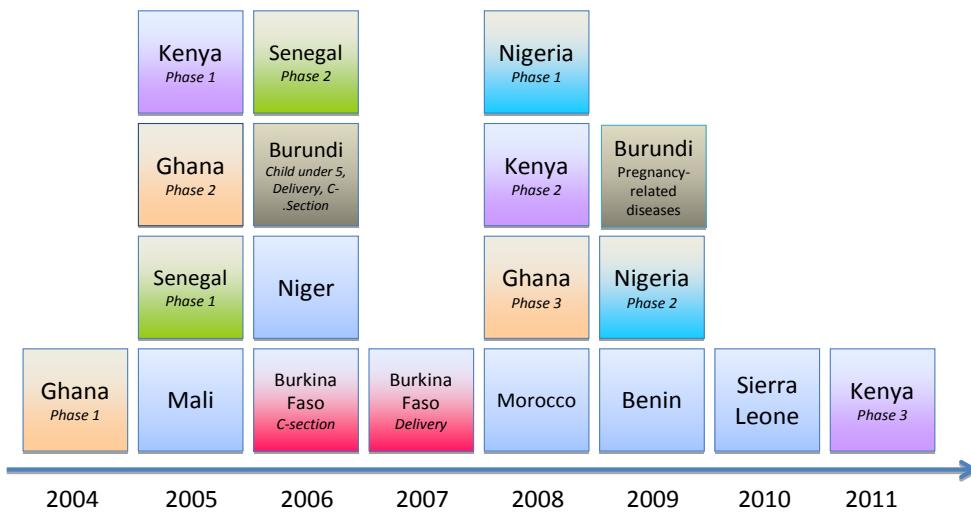
RESULTS

Timing of Introduction

The 11 policies were introduced between 2004 (Ghana) and 2010 (Sierra Leone). As shown in Figure 1, most have gone through a number of iterations (extending the geographical area covered, changing the benefits package and/or changing the delivery mechanisms and co-payments). For example, Senegal's fee exemption policy started in

2005 in five poor regions and was extended one year later to the rest of the country (except Dakar). In Burundi, the policy started in 2006 by covering children under 5, normal deliveries and Caesarean sections. In 2009, pregnancy-related diseases were added to the package of services exempted.

Figure 1: Chronology of the Policies' Introduction (n=11)



Benefits Packages

1. Who is covered?

Coverage involves several elements, including the population sub-group included, whether any income-based targeting is applied, the geographical areas covered, and the sectors included in the policy (see Table 1). The Benin, Mali, and Senegal policies cover only care for pregnant women while other countries also include care for the newborn. In Kenya, Nigeria, and Senegal, the policy covers targeted regions and not the whole country. Five countries apply the policy only in the public sector, while six countries have extended the policy to not-for-profit facilities, and even for-profit facilities with an accreditation process. The majority of policies apply to the entire population of pregnant woman regardless of their income, except for Kenya (whose policy targets poor pregnant women).

Table 1: Target Population of the Policies (n=11)

Country	Target group	Eligibility criteria based on income	Geographical coverage	Type of health facilities
Benin	Pregnant women with complications	NO	National	Public & non-for-profit
Burkina-Faso	Pregnant women (all) + new born with complication	NO	National	Public & non-for-profit
Burundi	Pregnant women + new born	NO	National	Public & non-for-profit
Ghana	Pregnant women + new born	NO	National	Accreditation (all types)
Kenya	Pregnant women + new born	For poor women only	Targeted regions	Accreditation (all types)
Mali	Pregnant women with complications	NO	National	Public
Morocco	Pregnant women + new born	NO	National	Public
Niger	Pregnant women with complications / new Born	NO	National	Public
Nigeria	Pregnant women + new born	NO	Targeted regions	Accreditation (all types)
Senegal	Pregnant women	NO	National (except Dakar)	Public
Sierra Leone	Pregnant women + new born /lactating mother (with children under two)	NO	National	Public

2. Which services are covered?

The only service that is covered by all 11 countries is provision of C-sections (Table 2). Eight of 11 countries cover normal deliveries.⁵ Two countries do not cover obstetric complications during pregnancy and labour, and four countries do not cover the complications during the post-partum.

Three categories of countries can be drawn from the table: (1) countries with a very comprehensive package (Burkina Faso, Burundi, Ghana, Morocco); (2) countries with a fairly comprehensive package, but that do not cover the complications related to abortion care (Kenya, Nigeria, Sierra Leone); and the last category: (3) countries with a very limited range of exempted services (Mali, Niger, Benin).

Table 2: Services Covered by the Policies (n=11)

	Morocco	Burundi	Ghana	Burkina-Faso	Kenya	Nigeria	Sierra Leone	Senegal	Mali	Niger	Benin
Antenatal care											
Delivery											
Episiotomy											
Complication during pregnancy				DC	DC			DC			
Complication during labour											
Caesarean section											
Other surgeries							Hyster.		Hyst+Ect.P	Hyst+Ect.P	
Postnatal care											
Postnatal complication											
Postnatal family planning				2		2					
Simple post-abortion care											
Complicated post-abortion care											
Newborn care						3	6			1	

 Covered by another exemption or subsidy policy

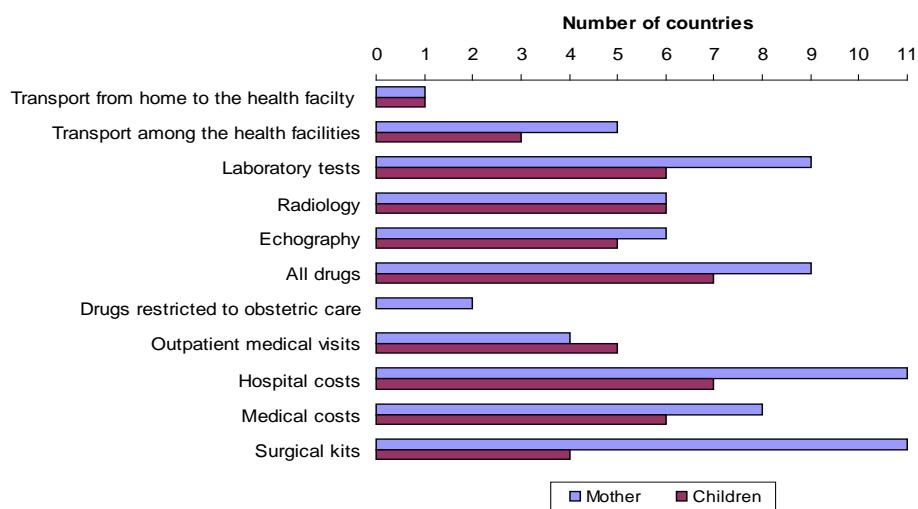
Note: DC=direct obstetric complications, hyster=hysterectomy, ect. p=ectopic pregnancy

3. Which types of cost are covered?

Figure 2 shows the types of costs covered by the policies. Surgical costs and hospitalisation costs are covered by all the policies, but complementary examinations like radiology, ultrasound, and even laboratory tests are not universally covered.

Few policies (five) cover the transport cost between health facilities. Only Morocco covers the transport cost between home and the health facilities (and that only in 24 provinces with poor access over 85 provinces). The range of costs covered is better for the mother than for the newborn. Under all policies, some household costs remain.

Figure 2: Costs Covered by the Fee Exemption or Subsidy Policies (n=11)



The majority of countries cover 100% of the direct costs of targeted services under the policy. Only two countries require some co-payment for the direct costs of targeted services: Burkina Faso (20% of direct costs are paid by the household) and Kenya (which demands a contribution of \$1- 2 per voucher. The voucher gives access to maternal health services: facility delivery or management of complications). Some countries have put in place a system of differing reimbursement levels to avoid self-referral to higher levels of the health pyramid. For example, in Burkina Faso, 80% of normal delivery costs are reimbursed in health centres, but only 60% in university hospitals. In Morocco, the exemption policy is applied in university hospitals for referred women only.

How Exemption Policies for Maternal Health are Linked with the Other Initiatives?

Exemption policies for maternal and neonatal care are not unique but one of a growing number of fee exemptions in many countries, which often have parallel policies targeting other disease or population groups (Table 3). Most countries also have a national policy to exempt the indigent from paying direct health care costs, but very often, they are not implemented in practice. Parallel to these initiatives, several countries (e.g. Ghana, Nigeria, and Kenya) have put in place a national health insurance system, while others are in the process of developing one (Mali, Benin).

Table 3: Other Targeted Exemption Policies

Countries	Tragedt population group				Targeted diseases or services				
	< 5 years preventive care	< 5 years curatives care	< 5 ans TB/Malaria /HIV	Ederly	TB	Malaria	HIV	Family planning	Other
Benin									Leprosy, Ulcer and Buruli, Onchocerciasis
Burkina-Faso									Surgical emergency
Burundi									
Ghana*									Psychiatric cases
Kenya									Séquelae sexual violence
Mali									NTDs, Leprosy, cervical cancer, Onchocerciasis,...
Morocco									Mammography, Iron deficiency Anemia
Niger									Women's cancer
Nigeria									
Senegal									
Sierra Leone									Leprosy
Total	7	4	8	3	9	7	9	7	

* Ghana has exemption for Children under 18 enrolling onto the NHIS.

(n=11)

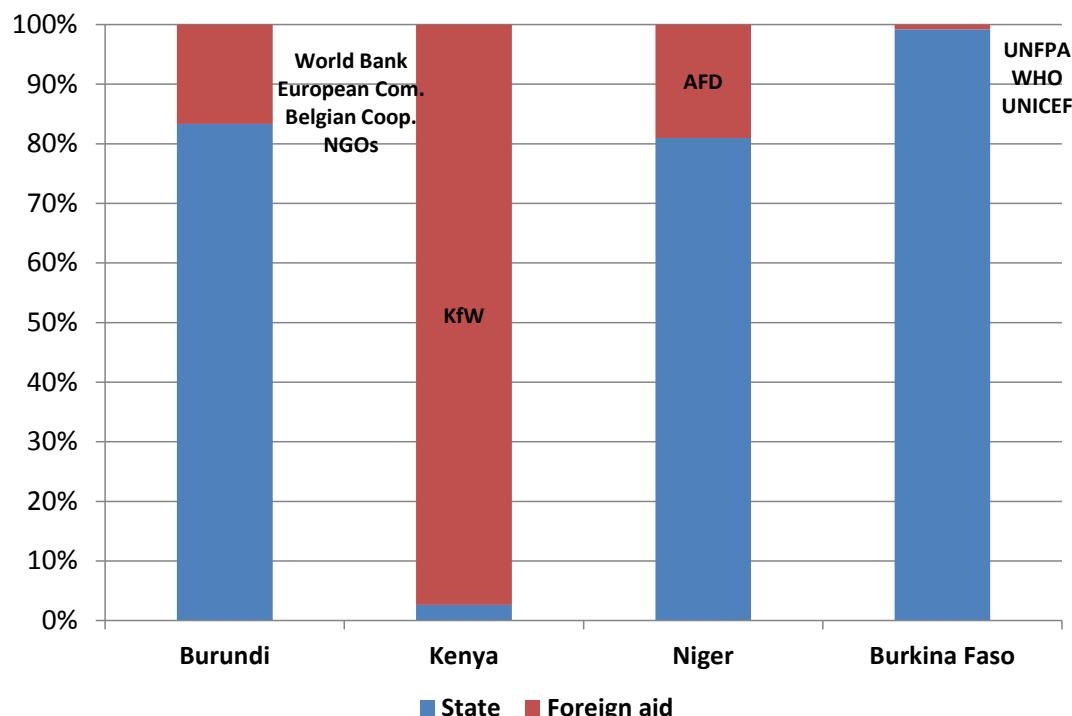
POLICY COSTS AND FUNDING MODALITIES

Revenue Collection

Funding sources for the fee exemption policy vary between countries. Some countries have relied solely on internal resources (Benin, Ghana, Mali, Morocco, Nigeria, Senegal), while others (Burkina Faso, Burundi, Kenya, Niger, Sierra Leone) rely on co-funding (at least to some extent) by development partners (Figure 3). With the exception of Kenya (whose policy - still a pilot project operating only in certain regions and parts of Nairobi - relies almost entirely on external funding from KfW), external funding accounts for a relatively small portion of funding of fee exemption policies (around 20% for Burundi and Niger, and less than 1% for Burkina Faso). Other countries, notably Sierra Leone, rely heavily on budget support funds to support the implementation of the fee exemption policy, even though they are not directly allocated to this programme as such.

Some countries have used resources from the HIPC (Heavily Indebted Poor Countries Initiative) to co-fund their fee exemption policies, as was the case in Nigeria, Ghana (phases 1 and 2), Burundi, and Senegal.

Figure 3: Share of External Funding in the Exemption Policy Funding (n=4)



External assistance is primarily, but not exclusively, monetary. In the case of Niger, for example, external funding is channelled through several mechanisms: provision of funding (AFD), drug supply (AFD, WHO, UNFPA, UNICEF) and contraceptive

commodities (UNFPA), and medical transport for referral (NGO HELP). Like Niger, the fee exemption policy in Burundi and Sierra Leone is supported by a multiplicity of donors. In the case of Sierra Leone, the most prominent are DFID (the UK Department for International Development), the World Bank, the African Development Bank, and UNFPA. All of these partners bring substantial technical support, as well as funding.

The length of donor commitment to funding fee exemption policies varies from country to country. In Burundi and Kenya, donors have made a financial commitment until 2014 (in Kenya, 344 million Kenyan shillings per year is committed until November 2014). For Niger and Sierra Leone, the period of donors' financial commitment was not provided. In Burkina Faso, donors have made no commitments but their support is marginal compared to the government's financial efforts.

Beyond the question of donors' financial commitments to support these policies lies the critical issue of sustainability. This is certainly the case in Kenya, whose policy is heavily dependent on external funding. In several countries, the policy has a flagship status for the president; in Burundi for instance, the president seems committed to protect his initiative (the country is even about to launch a national scheme to cover other categories of the population). But such political commitment can also encounter the difficult reality of budget constraints. Niger recently organised a national conference to assess the fee exemption policy: the 160 participants at the conference declared that "*the fee exemption policy was seriously sick and must be saved.*"⁶ The First Minister promised the creation of a fee exemption policy coordination body reporting to the First Minister's cabinet, as well as political commitment to address serious policy failures (underfunding, delays in reimbursement of the health facilities, poor management of the drugs supply chain, etc). Burkina Faso is the only country surveyed with an explicit multi-year commitment to finance the fee exemption policy (till 2015).

Pooling

In the 11 countries, these policies are funded by a single pool funded by tax payers or aid agencies; only Burkina Faso policy still stipulate that households have to cover 20% of the cost.²⁰ The entitlement is offered to all pregnant women in 8 of the 11 countries (Table 1). The three other countries have tried to implement a targeted approach to enhance the equity of the scheme, either by a focus on the poorest (Kenya) or on less rich regions (Kenya and Senegal). This indicates an overall equitable pooling of resources.

If there is inequity in terms of benefit-incidence, it might have two sources: (1) the barriers encountered by the poorest to access the services and (2) possible transfer of resources from this pool to another pool. It was not the purpose of this rapid study to enter these questions requiring substantial data collection. One can only hypothesise that a country whose policy covers also some of these barriers (e.g. Morocco and its broad assistance for transport) will fare better than a country whose policy leaves a small user fee by the user (e.g. Burkina Faso) or does not cover the transport (e.g. Niger).

Purchasing

Funding Modalities

Most countries pay facilities according to the number of services provided, though some pay in advance and others in arrears, and in some cases kits are an important component of the support to facilities. Benin, Burkina Faso, Burundi, Ghana, Kenya, Niger, and Nigeria pay retrospectively per service. In Mali, the supply of C-section kits is handled on a biannual basis and the reimbursement of health facilities is done on a quarterly basis. In Morocco and Senegal, prepayment of health facilities is done on an annual basis (for regional hospitals only in Senegal) in combination with the provision of delivery kits and medicines (Morocco) and C-section kits at the level of health centres in Senegal.

Different Levels of Reimbursement

Almost all countries have developed fixed reimbursement rates per service exempted, with the exception of Burkina Faso, which reimburses actual costs (retrospective fee for service payment to facilities). Some countries have varying reimbursement rates according to level of care (district/regional/national hospital) and type of facilities (public/non-for-profit/for-profit facilities); cost differences between levels of care are taken into account, with higher level facilities receiving higher funding. In Niger, for example, the reimbursement of a C-section in 2010 was \$320.6 PPP in a national hospital, \$200 PPP in a regional hospital, and \$140.2 PPP in a district hospital.

In another set of countries, the reimbursement rate depends on facility ownership alone. In Kenya, for example, in 2010 a C-section reimbursement was \$224 PPP in public health facilities, \$579.8 PPP in a faith-based or NGO facility and \$1040.5 PPP in accredited private hospitals. In a third set of countries, the reimbursement rate is fixed according to a combination of level of facility and its ownership. In Ghana, the reimbursement of health facilities is calculated using the National Health Insurance Scheme (NHIS) schedule. In five countries (Benin, Mali, Morocco, Nigeria, Senegal), there is a single rate regardless of the level or type of care. In Benin, all facilities performing C-sections are reimbursed \$426 PPP per C-section. In Nigeria, there is a mixed reimbursement mechanism: reimbursement based on outputs as well as a fixed amount of financial support per capita (based on the number of persons registered in the Health Management Organisation).

The extent to which the reimbursement rates are based on a real understanding of cost structures or costing studies is unclear. Previous studies have highlighted some differences between the cost of services and reimbursement rates.²¹ In Benin, the reimbursement is thought to be over-generous for district hospitals but not sufficient for the university hospitals (situational analysis of FEMHealth project in Benin⁷).

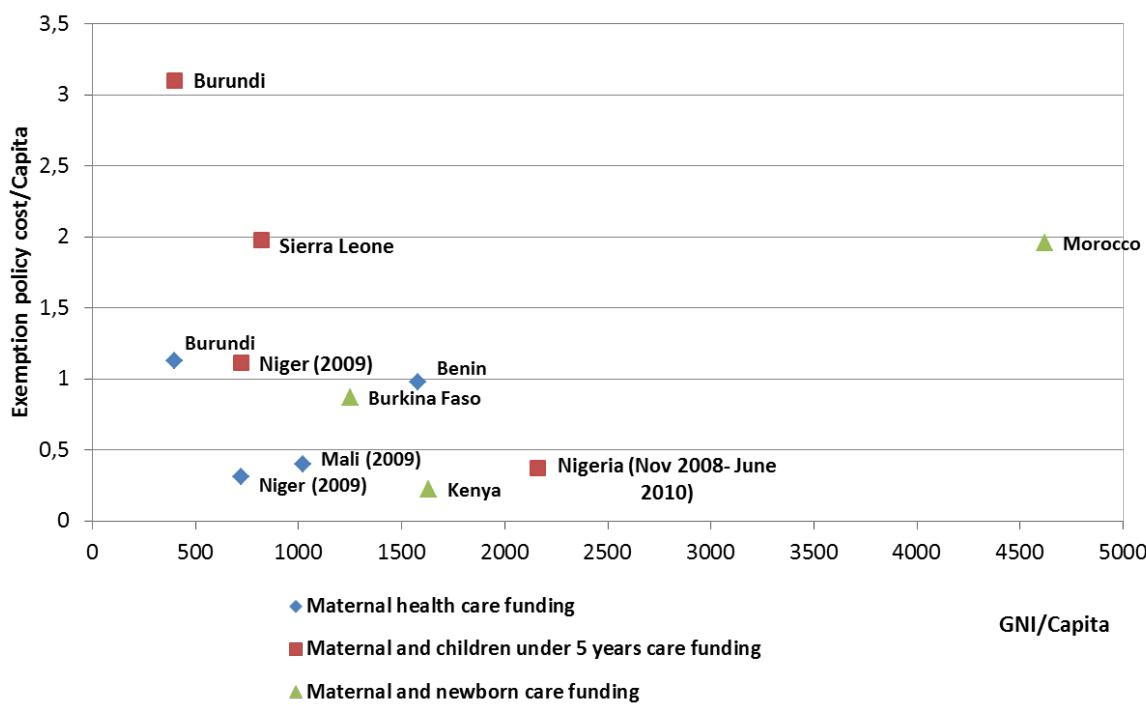
Cost of Maternal Exemptions

There is of course wide variation among countries in terms of the overall cost of the fee exemption policy, from \$62.8 million PPP in Morocco to \$4.8 million PPP in Niger. Size

of the population, economic development, scope of the benefit package, and also commitment by the government, are all factors affecting the budget available for the policy. The most interesting comparison is in relative terms.

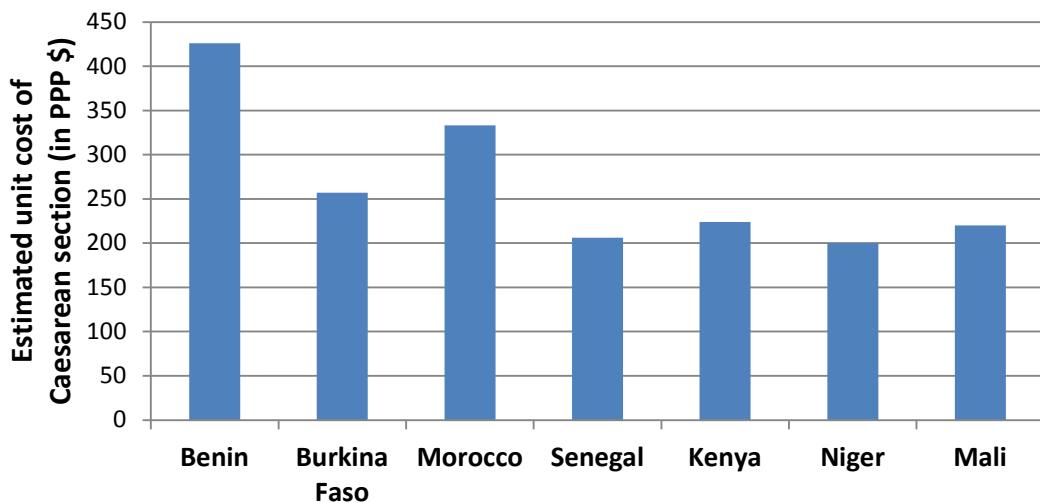
In Figure 4, the costs of the fee exemption policy per national capita are shown, according to gross national income (GNI) per capita. To facilitate comparison, policies have been presented in three groups according to their target population (pregnant women, pregnant women and newborns, pregnant women and children under 5). It is clear that the spending per capita is not well correlated with national income. These variations reflect a variety of factors, including differing entitlements within the policies, differing degrees of effective implementation, as well as different demographic factors, coverage levels, cost structures, and resource availability. Burundi is making the greatest effort relatively to nation's wealth.

Figure 4: Exemptions Policy Costs per capita, by GNI per capita (n=9)



We were able to obtain cost information for C-sections in seven countries (Figure 5), which varied substantially. In 2010, the direct unit cost of a C-section (surgical kits, drugs, inpatient stay) in Benin was estimated at \$426 PPP. This estimate is well above the estimates of Morocco (\$333 PPP) and Burkina Faso (\$257 PPP). It is double the estimated cost in Niger and Mali - respectively \$200 PPP and \$220 PPP per Caesarean section (in Niger, the unit cost varies with the level of care). These differences may partly reflect local medical cost structures, but may also reflect the different bargaining power of medical constituencies. Reimbursement systems varied across the policies and were not generally based on a full estimate of the costs of producing these services.

Figure 5: Estimated Unit Direct Costs of a C-section (PPP \$) (n=7)



DISCUSSION

Shared Goals, Shared Timing, Shared Learning?

With this review of 11 countries, we can see that there has been a strong movement over the past few years in Africa to prioritising financial access for maternal and child health, especially in the West African region. These shared goals and timing most probably have different drivers, some at global level (MDG 5; HIPC; advocacy by some global actors for free health care), some at national level (national elections).²²⁻²³ There is clearly room for cross-learning between countries and for knowledge strategies such as regional CoPs.

Understanding and Addressing the Real Costs for Households

These fee exemption policies are significant steps towards increasing access to priority services, however it is clear from the table on costs that none of these policies covers all costs relating to maternal and neonatal health care. Patients and their families are still responsible for covering at least part of the direct costs (especially laboratory exams, X-rays, and care of the newborn). Out-of-pocket payments can still be high in case of complementary exams.²⁴ Transport is also a serious obstacle for households – both financial and practical. Only Morocco covers transport costs from the home to the health centre in rural areas through an emergency obstetrical and neonatal transport system (SAMU), and only five countries cover transport costs between different health care facilities (in referral cases). In Mali, under the national fee exemption policy for C-sections, transportation is meant to be provided through existing referral systems that are supported by communities via solidarity funds; however since the policy's implementation, community mobilisation has decreased, leaving the emergency transport system very weak.²⁵

Even fee exemption policies that appear comprehensive on paper can engender high costs for households due to poor quality, uneven implementation, and lack of

monitoring. There are many reports of informal payments to medical staff, prescription of brand-name drugs instead of generic drugs, and/or recurrent shortages of drugs in the public hospital pharmacies that require families to buy drugs from private pharmacies.²⁶⁻²⁸ In short, it will be impossible to fully reduce financial barriers and reduce maternal mortality if health care standards remain inadequate or services are simply unavailable.²⁹ It is essential to invest in building adequate staff capacity and equipment before implementing such policies.³⁰⁻³¹ Increasing the uptake of poorly staffed and low quality health services can also add to, rather than reduce, health risks to women, neonates and children.³² In a nutshell, fee exemption policies alone are probably not sufficient to provide an effective coverage to targeted priority groups. There is a need for a comprehensive strategy, such as the one, which was developed by Morocco in 2008.³³

Still Insufficient Understanding of Incentive Issues

The rapid survey approach did not allow us to document the incentive dimensions of the policies. This would clearly require more knowledge on the performance of the country health systems, including efficiency at health facility level. This limit was illustrated during the workshop by an expert discussion about the Benin situation. Is the over-generous reimbursement to district hospitals and the 'insufficient' reimbursement to university hospitals a good thing or a bad thing in terms of the general organization of the health system? In many African countries, misdistribution of qualified staff is a major issue: city hospitals poorly performing because of a plethora of staff coexist with rural hospitals lacking the required expertise. From the perspective of the stewards of the health system, paying the C-section the same price whatever the situation or the level of the hospital could then be a way to improve the overall efficiency. These incentive considerations deserve more in-depth research.

The Risks of Focusing Too Exclusively on C-sections

The content of the package also needs reflection. The one service covered by the fee exemption policy in all of the 11 countries surveyed is the cost of C-sections. Other obstetric complications during labour are omitted in two countries: Niger and Benin. Post-abortion care is not covered in seven countries. There is a need to align benefits packages with current global evidence on maternal health.

While C-sections, as surgical procedures, are expensive to families, other direct obstetric complications, such as treating infection and eclampsia, are also expensive because of the costs of drugs.³⁴ Therefore, a policy focusing narrowly on making C-sections "free" does not eliminate the possibility of catastrophic expenses for families. It is also important to highlight that the major cause of maternal mortality in Africa is postpartum haemorrhage (33,9%) which cannot be treated by a C-section.³⁵ Indirect causes of maternal mortality (HIV infection, tuberculosis, malaria, severe anaemia, others infection) represent also a significant part (26,6% all causes confounded – 6,2% related to HIV) and do not require surgery but rather good primary and secondary prevention during antenatal care.³⁶⁻³⁷ To dramatically reduce maternal mortality, it is essential to move beyond C-sections and support more comprehensive emergency obstetric care measures, as well as to assure qualified assistance during delivery.³⁸

Studies carried out by WHO in Africa, Asia, and Latin America on modes of delivery and short-term outcomes for mother and newborn also show that C-sections actually increase the risk of mortality and severe complications for the mother (admission to intensive care, blood transfusion, hysterectomy).³⁹ C-sections carried out for non-medical reasons, either before or during labour, place women at greater risk of mortality or severe complications, particularly in Africa where health care standards tend to be poor.⁴⁰⁻⁴¹ During subsequent pregnancies, women who have undergone a C-section are at greater risk of uterine rupture or of implantation abnormalities (placenta praevia or accreta).⁴²⁻⁴⁴ Implemented as an isolated measure, without other accompanying measures and strategies to reduce maternal mortality, a narrow “free C-section” policy may lead to an increase of unnecessary C-sections. It is therefore important to monitor the evolution of the number of C-sections and their indications.⁴⁵⁻⁴⁶ The risk of supply-induced demand, particularly when C-sections are well reimbursed for providers, is non-negligible.

A general lesson for countries trying to move towards UHC by starting with schemes targeting priority groups (see below) is that it is crucial to involve specialised public health experts in the design of the policy.⁴⁷⁻⁴⁹

Fee Exemption as a Step Toward Universal Health Coverage

Whereas one can wonder whether these fee exemption policies will be enough to make rapid progress towards the MDG 5, there is no doubt that they are part of the national response to the political momentum created by the MDG agenda. As evidenced in the review, several countries have in fact adopted a fee exemption policy covering children under 5, which can be interpreted as an effort to accelerate progress towards MDG 4 as well.

As clearly stated by the WHO report⁵⁰ there is no single model to progress towards UHC. Yates has argued that fee exemptions for children and women would be a major step in the right direction.⁵¹ In terms of content of the policy, there is no doubt that removing user fees can – if the policy is well-funded and implemented – significantly improve access to the health services for substantial groups of users. It can also improve financial protection, especially when the benefit package includes services, which are very costly. In terms of process, one can also consider that focusing first on a vulnerable group such as pregnant women is an equitable route to UHC. The policy extends potential benefits to all parts of society, which also favouring the poor, who tend to have larger families and are also more likely to seek care in the public sector.

However, physical access to facilities is a major constraint, which discriminates against rural households. A priority is to ensure that barriers met by the rural poor are really addressed – to avoid that the policy mainly finances the privileges of the better-off living in the cities. Some countries in our review have been more attentive to others to this aspect. The second one is to handle the articulation of the exemption fee policy with the rest of the UHC agenda. This aspect seems to have been less well-handled in most of the reviewed countries.

Governance at the Country Level: Reducing Fragmentation and Complexity

We have seen that in many countries there is a panoply of fee exemption policies in operation: for communicable diseases, the poor, medical staff, etc.⁵² These different

initiatives lead to a complex architecture, with many actors and rules for eligibility. This complexity and lack of clarity make it difficult for the clients and for civil society to understand, and thus claim their rights. Even health staff can be confused by the plethora of policies, which are often poorly communicated and coordinated, leading to poor implementation and waste. Simultaneously, many countries are developing national health insurance schemes, and the relationship between insurance and exemption is rarely clearly defined.⁵³ In Sudan, for example, one study found a cross-subsidy of insured patients by the exemption policy for pregnant women and under-fives, but this appeared to vary by locality.⁵⁴ A similar problem has been identified in Burundi, where the civil servant insurance fund may have made big savings since the introduction of the free health care policy (as it is now the public budget which reimburses the facilities). The participants at the Bamako workshop reiterated the importance of having a coherent strategic vision for health financing, and the need to coordinate all health financing mechanisms to achieve the ultimate goal of universal coverage, through a sustainable system that develops over time to extend equitable access to health care for all.⁵⁵

Priorities for Further Research

The rapid growth in exemption policies focused on these target groups opens up a number of important research questions (Table 4). In particular, there are outstanding questions on the cost-effectiveness of this strategy, compared to alternative approaches, and a need for further research on their sustainability and how they can be linked into broader health financing plans.

Table 5: Outstanding Research Questions

Policy drivers

- Why were these particular policies developed?
- What were the drivers?
- What informed the different choices which countries made (situation analysis, research, priorities etc.)?
- What was the balance of internal/external factors?
- For international transfers, what were the mechanisms?
- Are we now shifting towards a more juridical approach to health (human rights, recent constitutional changes etc.)?

Impact on households

- What impact have they had on household payments?
 - Formal and informal
 - In public and private sectors
- What are the short and longer term economic and social impacts on the households?
 - Spending on other goods
 - Intra-household dynamics and allocation
 - Social relations

Impact on health

- How have the exemption schemes affected the quality of care?

- How have they affected utilisation (taking into account secular trends, and any changes to reporting)?
- What is their contribution to addressing the burden of mortality & morbidity?
 - Depends on services covered
 - Reaching right group
 - Delivered with appropriate care
- To what extent have they had adverse effects (e.g. over-medicalisation with C-sections)?
- Impact on equity and access
- How have the benefits of the policy been distributed, in terms of poorer women, women in more remote areas, and other marginalised groups?
- Have they addressed the most significant access barriers?
- Are the policies based on a consensus about priority groups?
- How have they affected social solidarity?
- How have they changed community perceptions and care seeking?

Impact on staff

- How well were staff working before?
What margin was there for additional effort?
- How has the removal of fees affected their financial rewards?
- How has removal of fees affected their non-financial (and intrinsic) rewards and their motivation?

Impact on facilities

- What are the financial implications of selective removal of fees for the facilities?
- How do they affect their accountability?
- How have they adapted to it (threats and opportunities)?

Impact on the health system

- What impact has the free care had on the system as a whole?
- Has it helped to integrate services or to fragment them?
- Has it added to or diverted finance, staff time, and resources for other services?
- Has it managed to catalyse wider health system strengthening?
- How have different sectors and provider types been affected?

How to set priorities

- How can different criteria be traded off (e.g. greater coverage versus broader package of services)?
- If you have limited funds, which services provide the best return?

Cost-effectiveness of policies

- What are the costs (total and marginal) of these policies?
- What are their transaction costs?
- What is the cost effectiveness of these policies?
 - These are financing policies, so often we are assessing not new services but changed incidence of costs, and/or improved distribution and/or improved quality
- How do their marginal costs and benefits compare to alternative possible use of the funds?
 - Costs localised; effectiveness varies; also need to think about funding source

and how transferable it might be

Sustainability

- Can the cost be sustained, now and as utilisation/coverage increases?
- What support is likely to be forthcoming, especially after 2015?
- What is the fit between exemption policies and overall health financing strategies? (Are they pulling together or pulling apart?)
- Are there synergies with other strategies (e.g. performance-based funding, decentralisation etc)?

Source: S. Witter, "Summary Presentation for Bamako Workshop," 2011

CONCLUSION

Selective user fee removal was developed by governments to address the urgent needs of priority groups in a resource-constrained context. However, the thinking behind these policies needs to be re-examined, as well as their potential integration into the system as a whole. The basis for selecting particular services would benefit from a discussion of the balance of risks – C-sections address potentially catastrophic costs, for example, but do not necessarily address the main health risks to women. They also present iatrogenic risks and a distinct risk of unnecessary medicalization. Ideally, packages of care should integrate care of mother and the newborn to a higher degree than happens at present. Preventive elements, such as family planning and antenatal care should also be part of the package, if possible, as they are highly cost-effective.⁵⁶⁻⁵⁷ For households, some costs which are very important barriers, such as transport, have been neglected.

Each context will be different and it is not appropriate to prescribe specific packages here. However, it is important that all policies have clear objectives and are based on an inclusive dialogue about local priorities, risks and resources.⁵⁸ They should also learn from evidence and from one another – an important objective for the CoP and also for this article. Finally, the policies should fit into a clear national health-financing framework, not operate as stand-alone programmes with limited reflection about how they interact with other initiatives. Reducing fragmentation is the best way to reach UHC.

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² This Community of Practice is supported by UNICEF, UNFPA, USAID, ECHO, EU (FP7 FEM health) website: <http://www.hha-online.org/hso/financing/subpillar/financial-access-cop>

³ PPPs can be defined as exchange rates that equalize the purchasing power of different currencies. Website: http://www.economywatch.com/economic-statistics/economic-indicators/Implied_PPP_Conversion_Rate/

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Changing from the “Pull” to the “Push” System of Distributing Essential Medicines and Health Supplies in Uganda: Implications for Efficient Allocation of Medicines and Meeting the Localized Needs of Health Facilities

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Uganda has undergone several reforms in governance of the health sector. One of the profound reforms has been the radical shift in management of medicines from the “pull” approach—health facility staff participated in determining the medicines needed, to the “push” approach—the distribution of a standardized kit of essential medicine to health facilities irrespective of the disease burden and patient population. This paper is based on multi-site, mixed method cross-sectional study on governance in the health sector commissioned by Transparency International. It revealed that this shift affected delivery of essential medicines for rural and hard-to-reach frontline health facilities. Although there were indications that centralization had minimized inefficiency due to over invoicing, abuse of medicine funds and re-allocating funds meant for medicines to other recurrent items, it led to the supplying of large quantities of medicines that are not aligned to the disease burden and needs of some health facilities.

INTRODUCTION

Since the late 1990s, the Government of Uganda (GoU) has carried out a number of health sector reforms, including the adoption of the sector-wide approach (SWAp) and decentralization of health service delivery.^{1,2,3,4} However, the processes for medicine supply were not reformed until 2002. In order to improve timely access, availability, and delivery of Essential Medicines and Health Supplies (EMHS), the Ugandan government has experimented with various supply chain models. Between 1985 and 2001, the health sector relied on the push approach, or essential drug kit supply systems, to deliver and distribute EMHS to all public health facilities.⁵

However, in 2002, the pull system was adopted; districts, local governments and health units requested medicines and health supplies that matched the disease burden, patient profile, and budget ceilings for EMHS for each respective budget cycle.⁶ The shift to the pull system was accompanied by intensive capacity building in supply chain management at national and facility levels. The capacity building efforts were supported and funded by health partners, specifically the Danish International Development Agency (DANIDA) and the United States Agency for International Development (USAID).⁷

After more than eight years of considerable investment in and experimentation with the pull system, it was abandoned in 2010 and replaced with a dual pull-push system. The pull system was maintained for Health Centre (HC) IVs and Hospitals, while the push system was adopted for rural and hard-to-reach health facilities—including HC III and HC II. The former (HC IVs and hospitals) were considered to have the human resources and technical capacity to effectively manage the supply chain,

while the latter were noted to have limitations in such capacity.^{8,9} A study undertaken at Kilembe Hospital in the Kasese district compared the hospital’s performance under the push and pull systems of drug supply; it indicated that the pull system reduced drug expiries and also improved the availability of and access to essential medicines and supplies.¹⁰ Increased access to essential medicines through an effective supply chain management system at the primary health care level is seen by others as a strategy for minimizing waste, dealing with ill health and reducing mortality rates, increasing responsiveness and drug availability, increasing choices and utilization, and promoting rational drug usage.^{11,12}

In this paper, we share insights related to the shift from the pull to push system of drug supply as seen through the lens of service users, frontline health workers and their supervisors, district and ministry of health officials, civil society representatives implementing health delivery monitoring programs, and other government officials linked to health services delivery and drug management in Uganda.

We explore issues and experiences related to shifts from the pull to the push system of delivering EMHS. We also explore how the change from the pull to push system of EMHS was managed and perceived by stakeholders. We argue that oscillation from the pull to push system without paying attention to existing evidence and involving stakeholders may create confusion in management of EMHS supply chains, leading to wastage of scarce resources. In addition, we note that the centralized character of the push system negates the aims of decentralization by limiting participation of leadership and health service governance structures at the lower government level where service delivery occurs.

The study was informed by the participatory development management approaches to policy and reform management, which emphasize participation and involvement of stakeholders in policymaking and health reform processes.¹³ The Asian Development Bank conceptualizes participatory development as “a process through which stakeholders can influence and share control over development initiatives”.¹⁴ Our analysis of participation of stakeholders in policy shifts from pull to push is also informed by Arnstein’s Ladder of Participation (1971), as well as by Kanji and Greenwood (2001).

According to this model, the intensity of participation is measured along the following parameters: compliance—where tasks with incentives are assigned but the agenda and process is directed by outsiders; consultation—where local opinions are sought, while outsiders analyze and decide the course of action; cooperation—where local people work with outsiders to determine priorities, the responsibility and to direct the process lies with outsiders; co-learning—where local people and outsiders share knowledge, create new understanding and work together to form action plans; collective action—where local people set their own agenda and mobilize to carry it out in the absence of outsiders.¹⁵

Despite some of the good intentions of the policy, the apprehension that some stakeholders have towards the pull to push shift modalities for managing medicine supply chains tend to reflect the tensions between the concentration of power at the national level at the expense of devolution at the district level.¹⁶ In turn, the centralized character of the push system may negate the aims of decentralization by limiting

participation of leadership and governance structures at the lower local government level where service delivery occurs.

METHODS

Setting

Data were collected as part of a larger, multi-site, mixed methods cross-sectional study on governance, accountability and transparency in the health sector, commissioned by Transparency International. However, in this paper, we only report the qualitative findings of the study. The study was conducted in 6 districts across the 4 regions (North, East, West and Central) of Uganda, from March to September 2010. The districts were selected taking into account regional representation, annual resource allocation¹⁷, performance on the Ministry of Health (MoH) league table¹⁸, and year of establishment as a Local Government (LG) unit(Table 1).¹⁹

TABLE 1: CRITERIA USED FOR SELECTION OF STUDY DISTRICTS

Region	Old versus New District(s)	Budget allocation	Performance League table
North	Oyam District (New)		Nebbi District (3 rd Best Performing)
East			Bugiri District(5 th Least performing)
West		Bushenyi District (High)	
Central	Masaka District (Old)	Kalangala District (Low)	

Study Population and Sampling Plan

The study population included serviceproviders, health services managers, and health services consumers. Key informants were drawn from the national and district health service delivery institutions including the MoH, the Medicines and Health Monitoring Unit (President’s Office), the Coalition for Health Promotion and Social Development (HEPS-Uganda), Public Procurement and Disposal of Assets (PPDA), Joint Medical Stores (JMS), and the Centre for Justice and Sustainability (CJS). Other key informants included local government officials from the study districts, such as members of the District Health Management Team (DHMT) and Health Unit Management Committees.

Sample Selection

Study participants were purposively selected due to their knowledge and current work experience²⁰ as well as to reflect regional balance in terms of urban and rural

locations, budget allocation patterns to districts, and the performance of districts according to the Uganda Ministry of Health League table.

Data Collection Procedures

Data was collected using key informant interviews (KII), focus group discussions (FGD), and group interviews/discussions (GIs) using guides developed specifically for each method. Sixteen KIIs were conducted with stakeholders at the national and local government level. Focus group discussions comprising between 5 to 12 participants were conducted with District Health Management Teams (DHMT), District Health Committees (DHC), Ordinary Community members, and the Health Unit Management Committee (HUMC) at Health Centre (HC) IVs. A total of 11 FGDs were conducted with ordinary community members in all study districts. Two FGDs were conducted with Health Unit Management Committees of HC IVs in Nebbi and Bugiri districts. Additionally, a total of 11 group interviews comprising 2 to 4 participants were conducted with the DHMT and Health Unit Management Committee (HUMC) at Health Centre IIIIs and IVs.

KII Participants were recruited at each study site by an interviewer associated with the project. Permission was sought from the relevant heads of departments. The department head identified the appropriate officials that lead or participate in the implementation of relevant programs. Potentially eligible officials were asked if they would be interested in talking to the study interviewer. Those that agreed were introduced to the interviewer, who described the study to the participant, determined their eligibility, and obtained their written informed consent to participate.

KII participants completed interviews in English, while FGDs were conducted in Luganda, Luo, Alur, or Runyankole, (the most commonly spoken languages in each region) by trained interviewers in addition to English, with answers written in English. To ensure consistency in interviews, all instruments were translated and back translated to check on accuracy.

Data was generated through a literature review of documents related to the study objectives/research questions. The literature review was based in a range of policy and program documents, including: annual health sector performance reports, sector analyses reports, health policies, strategic plans, district health records, and newspaper articles. From all these documents, we focused most on issues related to governance and accountability in the health sector as well as specific analyses of various mechanisms for distributing essential medicines and health supplies.

Ethical Considerations

Ethical approval was granted by the Uganda National Council of Science and Technology. All researchers were certified in human subjects' research. In addition, permission to conduct study activities was obtained from participating institutions or health units that served as recruitment sites. Written informed consent was obtained from all study participants in Luo, Luganda, Runyankole-Rukiga, or English, depending on their language of preference.

Data Management and Analysis

Interview guides utilized open-ended responses. Interviewers translated and transcribed open-ended responses during the interview. All interviews were recorded, transcribed and entered in Microsoft Word.

Qualitative analyses were performed for theme identification using a content analysis approach. Each interview was read and coded for themes, which were analyzed for frequency. Short answer responses (SAR) were coded for key themes by two independent observers. Coder responses were compared and collapsed into similarly grouped categories. Ten percent of responses were dual-coded to ensure inter-coder reliability. Selected quotes are employed to illustrate typical cases for the major themes that emerged.

RESULTS

Changes in EHMS Supply Modalities

Between 1985 and 2001, the health sector relied on the push system or essential drug kit supply system to deliver and distribute EMHS to all public health facilities.²¹ Under this system, the quantity of drugs supplied to lower health units was fixed and did not vary with the disease burden or patient load. Health units expected replenishments every quarter. This system, however, was fraught with many challenges, including frequent stock outages of essential drugs. For example, commonly demanded and prescribed drugs (e.g., ciprofloxacin, chloroquine, quinine, and analgesics and malaria injectables) ran out before the stipulated replenishment period, as other studies have previously reported.^{22,23} In addition, the top-down nature of the push system was also considered inefficient, difficult to track, and prone to waste through expiration.²⁴

In 2002, a demand-based(pull) system was adopted. The shift from the push to the pull system was informed by two studies, namely the Drug Tracking Study²⁵ and a Push-Pull Study.²⁶ Using the results from these two studies, a task force was set up to formulate an operational strategy for a transition from a supply system that was traditionally based largely on allocations of essential medicines pushed down from the centre to the districts, to a demand-based(pull) system.²⁷

Under the pull system, two financing mechanism for procurement of medicines and health supplies were instituted. The government continued to channel budget resources (including donor budget support) to districts for non-wage recurrent health expenditures, with the guideline that 50 percent of these funds would be spent on medicines.²⁸ Second, there would be new earmarked budgets for each district for medicines purchased from the National Medical Store (NMS (or Joint Medical Stores (JMS) for Private-not-For Profit (PNFPs) organization) in the form of ‘credit lines’ backed by centrally held funds at the MoH.²⁹ Therefore, under the pull systems, districts and health units were given more autonomy to requisition for medicines and health supplies that matched the disease burden, patients served, and budget ceiling for EMHS for each respective budget cycle.³⁰ The shift to the pull system sought to minimize stock-outs while increasing access and availability of EMHS in a timely manner.

After more than 8 years of considerable investment in and experimentation with the pull system it was abandoned in 2010 and replaced with a hybrid “push-pull”system—which involves a mix of pull and push systems. At the hospital and Health Center IV (HC IV) levels, the pull system was maintained while at HC III and HCII level the push system was reintroduced. The re-introduction of the push system was intended to reduce delays in requisition and procurement of EMHS, minimize risks of corruption in medicines procurement, and address the chronic drug stock-outs at the primary care levels—HC IIs and HCIIIs. In addition, the shift was aimed at reducing the burden on frontline health workers associated with requisition of medicines and other health supplies. Study participants observed that many of the health workers at HC III and HCII levels lacked adequate training in medicines quantification (i.e. quantify medicines requirements), and EMHS supply chain management.

“Some people [health workers] in the health units did not know all the required documents in medicines procurement and management like dispensing books. In some cases, these documents were available but the health workers did not know how to use them. These tools [documents] are not clinical, they are accountability documents, and most health workers did not know what to do with them.” (Group Discussion with Officials from Medicines and Health Services Monitoring Unit, Office of the President)

Perspectives on the Change from the Pull to the Push System

Study participants expressed mixed views about the move from the pull to the push system at HC II and III. Some participants were in favor of the move; they had the perception that the push system would improve equity and timely delivery of medicines and health supplies. One key informant noted that:

“The push system promotes equity at the low levels in the sense that standard drugs are delivered and made available. Quantification is done once and standardized kits are delivered at the health facilities. The kit system improves efficiency in management of the supply chain. It saves time and makes operational costs cheaper... You can predict what you will need ...with the push system, you need data at the beginning of the period and then that is all; the next phases involve packaging and pushing medicines to health facilities.”

Similarly, another key informant at the district level observed that the push system is more effective and efficient in the delivery and supply of EMHS. He noted that “in the push system, drugs [medicines] are delivered in time as per the schedule and also drugs are transported up to the health center” (Member of District Health Team, Bugiri District, Eastern Uganda).

Other study participants noted that the push system is relevant in resource constrained settings because it does not require highly qualified personnel at the lower level health facilities to carry out quantification of medicines and essential supplies on a

continuous basis. Instead, EMHS are supplied to health units based on historical consumption patterns:

“The push system does not need highly qualified staff [at the lower level health unit] to quantify medicines requirements because a standardized kit of EMHS is sent to health units....For pull system to be effective, health workers should have capacity to quantify according to need. Moreover, the medicines and health supplies’ needs keep changing in the health facility and across the country and as a result you may have so many varying needs. The Pull system is highly intensive because every clinic [health unit] procures according to need, [according to client load and disease burden]. Therefore health workers need to be trained in quantification. Thus pull is only effective at higher level health facilities” (KII, National level).

However, some study participants observed that the push system has a number of limitations in comparison to pull system. They noted that the pull system of medicines supply was more responsive to locally determined demand and disease burden. In the pull systems, health units were able to identify their specific needs and aimed at satisfying them as opposed to the push system where standard items and quantities are supplied irrespective of whether they were needed or not or sent to health units without determining what the specific need are at a particular time:

“The push system has problems of delivering drugs that are not commensurate to the requirements or the disease burden of the area. Some time they even delay to deliver drugs in time and they do not use the same people to deliver drugs... In the pull system we used to stock drugs for ourselves and packaging problems were not there because we could pack the right quantities and the right drugs. Therefore there was physical follow up of what was needed unlike the push system where you just receive drugs the way they are and sign because we cannot take them back.” (Key Informant, National level Civil Society Organization)

Others noted that the vertical supply of drugs does not take the consumption needs of the different health units into consideration, increasing the likelihood of under-supply or oversupply of some medicines. The latter may result into wastage and expiry of drugs that are not in high demand.

“Sometimes they supply fewer quantities of very essential drugs such as antibiotics and anti-malaria drugs and high quantities of less required drugs such as ant-diarrhea drugs.” (Official, District Health Management Team)

Tensions Arising from Change from Pull to Push Systems

The NMS is responsible for procurement and supply of the standardized kits of EMHS to health facilities under the push system. One of the significant changes that occurred in medicine procurement was making NMS a self-accounting entity with a separate vote of account. Since then, funds for drug procurement and supply are disbursed directly to NMS rather than through the “credit lines” system. Under the credit line system funds were disbursed to MoH and payments made to NMS upon supply of EMHS and presentation of invoices. This created a shift in power-relations between NMS and Ministry of Health (MoH), with the ministry’s role being limited to supervision and oversight, but with no control over resources for EMHS procurement and delivery. Study participants noted that the change in ministry power relations may have affected the morale, especially that of managers who provide NMS oversight.

The other significant change in EMHS supply management was the establishment of the Medicines and Health Services Delivery Monitoring Unit (MHSDMU) under the President’s Office. The unit is mandated to: “improve the surveillance of medicines and service delivery.”³¹ The unit created tensions because it was perceived to be duplicating the oversight functions of MoH, as its mandate overlaps with that of the ministry.

In addition, there was a general perception among study participants, especially at the local government level, that they were not involved in the process of deciding on the shift from the pull to the hybrid “push-pull” system. Key informants at the district, especially members of the DHMT, noted that their participation in such policy changes was limited to being informed about shifts, what to do, and enlisting their buy-in as opposed to being involved in the entire policy change process. As a result the shift was viewed with uncertainty and suspicion. In addition, the change was so sudden and drastic that the staff responsible for controlling the drugs from the Ministry of Health, the district and health unit, were for some time not sure of what would come next. They were concerned that changes would lead to changes in roles and eventually lead to loss of institutional and personal power that came with having control over the drugs and medical supplies.

Limited or no consultation with stakeholders on the policy at both the national and local government level affected the development and nurturing of a shared vision in respect to pharmaceutical management reforms. This may explain why some stakeholders developed apathy and are still grappling with this system of medicines management. Limited involvement of stakeholders has therefore affected ownership of policy reforms. It was also noted that the system is bureaucratic and less flexible in terms of accommodating context specific changes needed at the level of implementation. For example it was reported that if one health centre has medicines it does not need but are needed by another health centre, the exchange of such medicines has to be approved by the National Medical Store (NMS). This creates unnecessary delays that could be avoided if the District Health Team (DHT) had this mandate.

DISCUSSION

This study argues that while the push and pull systems of pharmaceutical management have context-dependent merits, the way they were implemented appears to be less systematic and therefore had several limitations.

The study reveals that the push system was implemented in a drastic fashion, as opposed to a systematic and gradual process involving all stakeholders. This engendered negative attitudes among staff and created resistance to change. The culture of originating policies from the top without meaningful participation of stakeholders, especially in the context of decentralization, institutionalizes top-bottom approaches that inhibit development of sustainable policy and institutional frameworks.³² As a result, in resource-constrained settings like Uganda, such drastic policy shifts do not get owned by stakeholders and may not lead to desired outcomes.

Our data show that limited participation of frontline health workers at HC III and II, may render them less likely to share in the vision, which as has been argued elsewhere stifles policy implementation and sustainability.^{33,34,35} Evidence shows that when individuals don't feel appreciated and involved in creating the change likely to impact their lives, they tend to be demotivated and thus unable to appreciate and participate in change processes.^{36, 37}

Our study demonstrates that the push system improved availability of essential medicines. This is in line with findings of a recent assessment of the kits-supply order system, which indicated that there was improved availability and access to vitalEMHS at the primary care level. Additionally, it reduced average stock-out days per month for all EMHS in the facilities from 20 days to 5 days.³⁸ However, 63% of items were oversupplied with the risk of expiry; 18% and 22% of the EMHS supplied in the HC II and HC III kits, respectively, were inappropriate for the primary care level and should only be used at a higher level of care (HC IV and hospital).³⁹ Under the push system, the kit does not vary with disease burden and patient load. Furthermore, over supplied drugs are not easily exchangeable at the district level without NMS involvement, which is bureaucratic.

CONCLUSION

Our findings suggest that despite the progress made over the years in implementing reforms in pharmaceutical management systems to improve access to health services, there are still institutional bottlenecks to effective performance of EMHS.

Our study argues that regardless of the pharmaceutical supply and management system adopted, the involvement of stakeholders in EMHS policy reforms, especially local government health managers, frontline health workers and health users, is crucial for developing a shared vision, acceptability and ownership of the reform processes and outcomes. A reflection on the model of participation by Kanji and Greenwood indicates that the policy processes that characterized the management change from pull to the hybrid pull-push fell short of most of the participatory tenets. Our findings suggest that the limited responsiveness of the push system to the local and context-specific needs of frontline health facilities is a critical limitation that needs to be addressed in order to improve delivery and access to EMHS. Our study also points to the need to streamline communication strategies for policy and reform processes in order to minimize anxiety, uncertainty, suspicion and resistance from stakeholders. In addition, our findings indicate that the centralized character of the push system negates the aims of decentralization by limiting participation of leadership and health service governance structures at the lower government level where service delivery occurs. This may affect

capacity building and developing institutions at the local government level to effectively manage EMHS.

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Achieving Universal Health Coverage: State of Community Empowerment in Bangladesh

Taufique Joarder, Aftab Uddin, and Anwar Islam

Initial attempts at Universal Health Coverage (UHC) meet with resistance from different quarters. Therefore, it is imperative to empower the community and generate demand for it. This paper argues that community empowerment can facilitate health equity either directly or indirectly through facilitating UHC. In order to empower the community, first it is important to know its status, which was the aim of this study. The mixed method research found that 90% of people had some source of information, but there was almost absolute lack of empowerment in terms of participation in decision making, demanding accountability, and local organizational capacity. The knowledge obtained by this research can help policy makers to make evidence-informed decisions towards achieving health equity.

BACKGROUND

Debates around Community Empowerment

'Community Empowerment,' as the name itself implies, means the process by which relatively powerless people in the community work together to attain control over the events influencing their life. However, the term 'community empowerment' has traditionally been mentioned loosely, especially by policy makers and NGO movers. In some literature, the terms community participation/involvement,¹ social capital, community capacity,² human capability,³ community competence, and community cohesiveness⁴ have been used either synonymously with, or with subtle distinction from, the term 'community empowerment'. While 'community empowerment' is similar to these other terms, it has a different meaning. The concept became popular in the development field during the 1980s, with the emergence of the 'new health promotion' movement, the focus of which, in keeping with the emergent concept of community empowerment, was to achieve equity in health and to increase public participation in health program decision-making.⁵ However, the origin of the term as a theory is linked with the Brazilian humanitarian and educator Paulo Friere's seminal works 'Pedagogy of the Oppressed' and 'Education for Critical Consciousness'.⁶

The term has been defined from different perspectives by different academics and researchers. Laverack identified nine domains of community empowerment, which are as follows: participation, leadership, problem assessment, organizational structures, resources mobilization, links to others, asking 'why,' program management, and the role of the outside agents.^{7,4} While the connotation of 'community empowerment' varies across peoples, countries, and cultures, the concept shares some common underpinnings. For example, it universally applies to the individual as well as the community; addresses the issue of controlling direction of resource flow in the community and one's own life; addresses the issues related to capacity and confidence

building; and considers active participation as a necessary, but not sufficient condition for community empowerment.⁸

Different disciplines (e.g. community psychology, nursing studies, management, health studies, political theory, social work, education, women studies, and sociology) have used this concept from their own perspectives.⁹ Psychological studies have sought to understand whether 'empowerment' is a process, an outcome, or both; and also to understand the nature of 'empowerment' at the individual level, with respect to the group, and at the community level.¹⁰ During the 1990s, an increasing number of nursing studies were conducted on 'empowerment' issues. According to a literature review by Kuokkanen and Leino-Kilpi, the concept has been utilized in the nursing field largely to understand the interplay of power dynamics among nurses; between nurses and patients; and between nurses and other health care professionals.¹¹ In the domain of public health, Laverack explored the role of community empowerment in improving health outcomes in an extensive review of literature published between 1992 and 2005.⁷ In the realm of health promotion, the debates on community empowerment have been dominated by the ethical dilemmas emerged from tensions between the top-down approaches of some health promoters and the bottom-up demands from communities for certain interventions (which were seen as ill-advised, or even harmful, by health promoters).^{12,5} Finally, the concept of Primary Health Care adopted 'community participation' as one of its principles since its inception in 1978. The term 'community participation' has been gradually replaced by 'community empowerment' since the 1990s.⁸ Given the increasing interest in Universal Health Coverage (UHC), we argue that empowerment issues need to be extensively explored in the context of UHC as well.

Achieving Health Equity through Community Empowerment

Inequities are subset of inequalities that are considered unfair and are potentially avoidable.¹³ There is a malignant discrepancy in health outcomes as well as health care utilization between rich and poor countries and within countries across socio-economic strata.¹⁴ Unequal social and political conditions are pushing 25 million households each year towards abject poverty as a consequence of health care payment. Worldwide, 1.3 billion people do not receive necessary drugs or surgery because they cannot afford them.¹⁵ In order to alleviate this problem multifaceted interventions, designed to be reinforcing rather than mutually exclusive, have to be put into action. This paper considers 'community empowerment' to be one of the interventions that can contribute, both directly and indirectly, to achieving health equity, particularly in the context of Bangladesh.

The link between community empowerment and health equity has been explored in a number of seminal publications, including 'The World Development Report 2000/2001,' and Nobel Laureate Amartya Sen's book 'Development as Freedom.' The World Development Report 2000/2001, based on its qualitative and quantitative evaluation of poverty and inequity all over the globe, made three specific policy recommendations, including 'facilitating empowerment' (others were 'promoting opportunity' and 'enhancing security').¹⁶ In his book, Sen argues that capability deprivation leads to compromised freedom. He cites data to establish a crucial link between equity and empowerment.¹⁷ In her 2003 paper, "A framework linking

community empowerment and health equity," Susan Rifkin notes that this linkage has also been explored and discussed extensively by other scholars.⁸

Community empowerment promotes health equity, in that it is imperative to achieving UHC, and UHC is integral to health equity. Evidence from different countries suggests that initial attempts at establishing UHC meet with resistance from different quarters, such as professional associations of physicians or from national financial experts.¹⁸ Some resist UHC due to vested interests, while others resist because of a lack of understanding of the idea, or as a result of a habitual antagonism towards anything new. In the context of Bangladesh, which is a majority Muslim country, health insurance may be regarded as associated with commercial insurance, which many consider as haram (prohibited from an Islamic point of view). and Adoption of prepayment-based health financing may be resisted for this reason. Therefore, it is the people who should be informed and convinced first to demand their health entitlements based on informed decisions.¹⁰ Experiences from successful programs suggest that popular demand can be effectively generated through the concerted effort of the people themselves, guided by civil society.¹⁸ Hence, 'community empowerment' emerges as an important prerequisite for establishing UHC.

There is a convincing body of evidence available to attest to the necessity of a prepayment-based health financing system, which is the heart of UHC, for ensuring health equity. The World Health Assembly in 2005 unanimously adopted a resolution urging participating governments to achieve the following two goals, which were eventually termed UHC: 1) provide all people with access to required health services sufficiently and effectively, and 2) ensure that the services do not push the users into financial hardship. In line with this proposition, Cambodia, Kyrgyzstan, and several other countries introduced health equity funds. This increased the utilization of health facilities and decreased borrowing money for healthcare by the poorest population groups.¹⁹ In Mexico, introduction of the public health insurance program 'Seguro Popular' (People's Insurance) resulted in improved health service utilization and financial protection.²⁰ Therefore, it can be rightly argued that introduction of UHC can effectively interrupt the vicious cycle of illness, impoverishment, further illness, and, consequently, aid in achieving health equity.²¹

Our view in regards to the relationship between community empowerment and UHC boils down to the conceptual model shown in Figure 1.

Community Empowerment in the Context of our Study

The research on empowerment was originally nested in a broader research project which aimed at developing a model for comprehensive primary health care (CPHC) in Bangladesh. Our proposed model of CPHC raised the demand the inclusion of 'community empowerment' as one of its components. This necessitated the evaluation of the current status of 'community empowerment' in Bangladesh. The researchers had to accommodate the 'community empowerment' component in the greater scope of the CPHC research project in a practical and operational fashion. As described in the opening section of this paper, 'community empowerment' has been defined by different disciplines differently; adding more complexity to the already complex concept. Therefore, like many others conducting research on community empowerment, it was crucial to provide adequate clarity to the concept and to make it practically

operationalizable.⁴ Drawing upon this understanding, our rigorous literature review led us to adopt an operational definition based on the following four parameters:²²

1. **Access to information:** Informed people in the community can take advantage of opportunities, access services, claim their rights, negotiate effectively, and hold the actors responsible for their actions. Access to media (e.g. radio, television, and newspaper) was considered critical for accessing information.
2. **Inclusion and participation:** It is important to know whether the community members are included in decision making forums and whether they can effectively participate in the discussion and decision making.
3. **Accountability:** The ability of community members to hold public officials, or service providers, responsible for their decisions and actions. Access to information feeds into the capacity of the community to hold the responsible persons accountable.
4. **Local organizational capacity:** The ability of community members to work together, organize themselves, and mobilize resources to solve problems of mutual interest.

In the second section of this paper we describe how community empowerment is crucial to achieving health equity. In order to empower the community, first it is imperative to know the present state of community empowerment in Bangladesh, to be able to provide informed policy feedback on areas requiring enhanced emphasis. Therefore, the aim of this study was to understand the current status of community empowerment in Bangladesh, and to explore suggestions from community members themselves.

METHODOLOGY

Study Design and Sampling

The study adopted a mixed-method design. The first stage of the study was comprised of Key Informant Interviews (KII) to gain conceptual insight into the matter. Key informants were selected purposively, and included one government high official from the Directorate General of Health Services under the Ministry of Health and Family Welfare. They also included three veteran public health professionals, who were involved in early stage policy formulation and implementation of Primary Health Care (PHC). We also interviewed a Public Administration specialist from the University of Dhaka, who conducted doctoral research on the health policy process of Bangladesh and helped us to understand the critical underpinnings of community empowerment in the realm of health systems.

The second stage of the study involved focused ethnographic study (FES) in two Upazila Health Complexes (PHC centers at the sub-district level), a household survey in a randomly selected village within the catchment area of each Upazila Health Complex, and Participatory Rapid Appraisal (PRA) in the same two villages. The Upazila Health Complexes were selected as part of the greater CPHC research project, in which WHO Health Systems Performance Assessment Guidelines²³ were used to rank 20 Upazila Health Complexes based on their performance. The second stage of the study was conducted in the 'highest performing' as well as the 'lowest performing' health center. In

order to perform the household survey and the PRA, a list of all the villages in the respective Upazila (sub-division) was compiled and one village from each Upazila was selected randomly.

The FES involved observation for two weeks of patients utilizing the Upazila Health Complexes. In-depth interviews were conducted with two local government leaders (one in each site), 15 health service providers (total number), and 20 service seekers (total number). Respondents for in-depth interviews were selected purposively. For the household survey in the village, a systematic random sample of 5% of the total population was interviewed. The PRA session was arranged with the help of the local leader, and 30 people (both male and female) from different socio-economic strata participated in each of the villages.

Study Site

One of the two health complexes where the second stage of the study was carried out was Dhamrai Upazila Health Complex, located 20 kilometers west of the capital city of Dhaka. This health center was identified as the 'highest performing'. A household survey and PRA was conducted in the nearby village of Kashipur. The health complex is located adjacent to the Dhaka-Aricha highway, one of the busiest highways in the country. Dhamrai Upazila had a very good communication facility, which was approachable both by road and river.

On the contrary, Mehendigonj Upazila Health Complex in Barisal district was identified as the 'lowest performing' health center. The village of Charlata was selected for the household survey and the PRA. Mehendigonj is an Upazila of Barisal, one of the southern districts of Bangladesh, crisscrossed by many rivers, making communication very difficult. While Barisal city is approachable by road and river as well, our study site Mehendigonj Upazila was approachable only by river.

Data Collection and Analysis

A range of tools and techniques (e.g. checklists, semi-structured questionnaires, PRA guidelines) were pretested and employed to collect data for this study. Qualitative data were collected using checklists and PRA tools; and quantitative data were collected using a semi-structured questionnaire. Quality control visits were made during data collection. Qualitative data were collected by researchers trained in medical anthropology. A field research assistant was recruited and trained to conduct the household survey. The interviews were all tape-recorded and transcribed. Qualitative data were coded according to grounded and a-priori themes using ATLAS.ti5.5 software. Quantitative data were analyzed using SPSS version 13.0.

Ethical Considerations

Respondents agreed to take part in the research by giving their written informed consent. They were informed about how they were selected, about their rights not to answer the questions, to leave the project any time, to be protected from revealing their identity, and to know their roles in the process of collecting data before joining the project. Each respondent was compensated for his or her time by a gift item offered by

the research team. The researchers also responded to the queries at the end of each conversation. The research project passed through the Ethical Review Committee of James P Grant School of Public Health, BRAC University, and received due approval.

RESULTS

Background Characteristics

Respondents, although drawn from two distant areas of Bangladesh, were similar in many respects. Gender distribution, mean age, marital status, age of marriage, and family size were considerably similar in the two villages. However, we observed some differences in terms of educational qualification, household income, and occupational profile. In the village of Kashipur, situated near the capital city of Dhaka, respondents had better education, occupations, and income. Almost half of the respondents in Kashipur were illiterate, whereas the literacy rate was as high as three-quarters in the distant island of Charlata. In Kashipur, 37% of respondents belonged to the highest income quintile, whereas in Charlata only about 5% belonged to that group. There were also differences in the livelihood pattern (Table 1).

Access to Information

Household Survey Findings

Every individual had access to some source of information through mass media- 43% of people had at least one household member with a mobile phone – but the type of mass media providing the most health information varied between the two villages. Kashipur, being close to Dhaka, had better network access to television, whereas radio was the main source of information in Charlata (Table 2).

Television was used by the people from the highest two income quintiles, whereas radio was used by the lowest two. Newspaper was found to be a largely unused media (Figure 2).

Qualitative Findings

The Bangladeshi government has made it mandatory to mount the Citizen Charter in all government facilities in order to inform the people of their entitlements. In Dhamrai, the Citizen Charter was not only visibly placed but also a large billboard was erected at the main entrance of the health complex to inform the patients about available facilities. In addition, available services were enumerated on a black board in a familiar language inside the health complex building. The Chief of the health complex held regular monthly coordination meetings with field staff where he urged them to inform the rural patients about available services. Many services (e.g. Caesarian Section delivery) were made popular through this approach among the poor rural population. Local music groups were also used to inform people of available health services. Relevant services were also advertised in mosques by the Imams during Friday prayers, and during Hindu religious sessions.

The initiatives to inform people about health services in the island health center of Mehendigonj were quite the opposite. We found a Citizen Charter in the center, but it was placed in a shabby corner, on a damp wall where hardly any patients would view it. The Chief strongly acknowledged the importance of the Citizen Charter, but expressed his skepticism of its utility given the low literacy level among the people. But he expressed his optimism about the government's newly launched Community Clinic program, which he believed would bring health care closer to the people. Acknowledging the importance of community empowerment through information, he opined that Community Clinics can serve the purpose of informing people of their health entitlements as well.

Inclusion and Participation

Household Survey Findings

63% of respondents in Kashipur said there were no decision-making forums on health, while 35% said that they did not know whether there were any. In Charlata, all the respondents said that there were no such forums. None of the respondents had ever participated in any type of decision-making forum on health issues. The only two persons who reported that they participated in a decision-making forum said that their opinions had not been taken into consideration.

Qualitative Findings

Almost none of our patient respondents were found to be involved in a forum where issues related to health are discussed and decisions are made. Only one person, who was a Village Organization (VO) member of BRAC (a renowned development organization based in Bangladesh), said that she regularly attends weekly health meetings organized by BRAC where they discuss different health issues and how they can get involved in improving community health. All of the respondents unanimously and strongly expressed their opinion that such a forum is necessary.

When asked why they were not involved with such initiatives, the answer was plain and simple: "There is none". One respondent from Dhamrai said: "There are big people like doctors; among them how do I expect to make a scope to talk?"

Another patient from Mehendigonj also had the same expression: "Even if I want to get involved, they will include only the local elites. They will never include common folks like me."

Accountability

Household Survey Findings

Since there was no formal way of demanding accountability from decision makers, we used a 'client feedback mechanism' as a proxy. 93% of respondents from Kashipur said that they did not know whether there was any client feedback mechanism. In Charlata, 99% of respondents said that there was no formal client feedback mechanism. 83% of people in Kashipur and 100% of people in Charlata suggested that a person must be

appointed at the health center to listen to their complaints and suggest a solution. 15% of people in Kashipur suggested that a complaint box be installed for that purpose. A list of suggested methods of client feedback is shown in Table 3.

Qualitative Findings

One patient from Mehendigonj acerbically remarked, "Here we get some medication however trivial it might be; that's all we can expect. How can we hold these important persons responsible?"

There was no formal way to challenge the accountability of the health complex personnel. As a result, a set of informal ways had developed, ranging from shouting and quarreling to even inflicting physical abuse on health care providers.

According to the government directive, previously every health center had a Health Management Committee headed by the Upazila Chairman (local government leader). According to a decision by the government, the local government leaders were removed from this responsibility and replaced by the local Member of the Parliament. Tensions raised by this decision eventually led to inactivation of the whole committee in many health complexes. Local government leaders felt that, on account of their greater involvement with the common people, they deserved more authority to monitor the health complexes, and ensure greater accountability of the health complex personnel.

We heard many stories from the patients about negligence and misbehavior of the health care providers, about which they could do nothing. According to patients, accountability was there, but it could only be sought by the influential people, not by common patients like them.

Local Organizational Capacity

Household Survey Findings

One of the proxies used for understanding the local organizational capacity was to explore whether communities could contribute, by any means, to the different government initiatives. Half of the respondents from Kashipur expressed their ignorance over the issue. In Charlata, all the respondents said that there were no such means. None of the respondents in any of the villages were found to have any experience of working in partnership with the government health services.

Qualitative Findings

Bangladesh is a disaster-prone country. During natural calamities people from all walks of life voluntarily collaborate with government bodies, including the Upazila Health Complexes. However, unfortunately, this enterprising practice is not nurtured during other times, especially in regards to health activities.

One of the most successful government programs was the Expanded Program on Immunization (EPI), which was also a great example of partnership of the people with the government. Community volunteers were recruited and trained by the health department, and the program became very successful. Reflecting on this success story, one Medical Officer (physician) at Dhamrai health complex told us, "You know about

the monumental success of National Immunization Day (NID) and EPI. Because of this program Bangladesh became free from polio and it still is. This reputation could never have been achieved without the participation of the people”.

The recent Community Clinic approach of the government also depended greatly on voluntary contributions from the people. Government was only responsible for building the structure, supplying the equipment and medicines, and employing staff. The community was responsible for management, maintenance, and security, and the land was donated by the local people.

Suggestions from Respondents

The PRA method helped us obtain suggestions directly from the community members about ways to empower them. They maintained that participatory research itself can be regarded as an empowering tool. Some other suggestions emerging from the PRA sessions include: 1) training the community members on health issues so that they in turn may educate other people in the community; 2) galvanizing already existing health education program; 3) organizing health education sessions regularly on the health complex premises; 4) involving mass media (radio and television) more closely to inform people of their health entitlements; 5) involving the local government to carry out health education programs; and 6) revitalizing the school health education program. In addition to the PRA, key informants, service providers, and service seekers at the health complexes made additional suggestions as follows.

Respondents shared innovative suggestions for how to empower them to attain their health entitlements. Information is imperative in empowering the community. Mass media, as noted by the respondents, can play a pivotal role in informing people of their health entitlements. In addition to that, materials outlining health entitlements and the available facilities in the nearby health centers could be developed to supplement existing Behavior Change Communication (BCC) materials, which concentrate on health practices only. There is already a wide network of government health workers who are primarily responsible for disseminating health education messages. These existing workers can play a fundamental role by informing people about the available services and the entitlement of the people, in addition to their usual health education messages. A more active role for the local government was also recommended as a factor in community empowerment. Local governments can organize regular community meetings where health issues can be discussed. These local government meetings can also pave the way for the community members to express their complaints and experiences regarding their encounters with health facilities.

Involving the males in the community was suggested by one key informant, who said, “I experienced that if males are motivated they can be supportive towards their female counterparts. Most of the health and development programs are targeted towards females in Bangladesh. However women empowerment is essential, it should be achieved through the understanding, responsiveness and involvement of males as well. If males were not supportive, micro-credit programs of Grameen Bank or BRAC could not be successful.”

It was suggested that people of the community must be involved in such a way that they develop a sense of ownership of the health center. Local people and local governments must have a mechanism of monitoring and ensuring transparency and

accountability of the health center staff. Local health authorities, including people from different arenas (e.g. local government, civil society, and other government cadres) can be commissioned to form an authority mandated to monitor and provide feedback. But above all, the level of education of the population must be improved and updated health issues should be addressed in the school curriculum.

DISCUSSION AND CONCLUSION

Owing to the good mobile network and affordable cost of mobile connection, many people use mobile phones even in rural areas of Bangladesh. Labrique et al. found 45.1% household ownership of mobile phone in rural Bangladesh,²⁴ which is similar to our findings in this study. Television and radio are also widely available; however, their use varies across regions and income groups. When deciding on the best mediums for health message delivery, this finding regarding the variability of communities' main sources of information should be kept in mind. Information targeted towards lower income groups can be more effectively distributed using radio instead of television or newspaper.

The importance of informing people of their health entitlements has been acknowledged by the government. However, there are two major caveats to achieving the objective. First, the implementation of the government order of informing people of their health rights is not uniformly implemented throughout the country. This is again related to other macro-level factors such as monitoring, resource availability, and commitment of personnel. Second, low literacy rates can inhibit achievement of the desired outcomes of the government directive. Education is a prerequisite for realization of the right to information, and Bangladesh is grappling with an adult literacy rate of only 56%.²⁵

Inclusion and participation, accountability, and local organizational capacity are the domains which cut a sorry figure according to our study. There were hardly any reported instances of health-related community engagement. Even where there was, it was perceived by the respondents to be ineffective. The issue of social hierarchy, and the distance between service seekers and service providers appears to be an important obstacle to inclusion and participation of community members, as well as to their ability to challenge decision makers about their deeds. Zaman described how extreme inequalities in power, influence, and opportunity create hierarchical behavior in countries like Bangladesh. He demonstrated in the context of a hospital ward in Bangladesh how patients are scolded and humiliated by all levels of health care providers, even the lowest level staff- the ward boys, and the cleaners.²⁶ This issue transfers to settings like the health complexes where we conducted our study and which are similar to small hospitals located in Upazilas.

Despite the dismal picture in the latter three domains of community empowerment, our study shows that there is persistent demand from the community for achieving goals in those domains, as reflected by community members' suggestions. The people of Bangladesh have a long history of social movements and successful collaboration with government initiatives. Unfortunately, many of those instances are limited to sectors other than health. In the health sector, the few examples are the Expanded Program on Immunization (EPI), Directly Observed Treatment-Short Course (DOTS) for tuberculosis, and family planning programs. These models deserve to be replicated in many other health programs in Bangladesh. The EPI program is a good

example of community involvement in a government-run program²⁷ – one that achieved a 95% child DTP3immunization rate, one of the highest in South Asia.²⁸ The vibrant NGO movement in Bangladesh is also a testament to the social consciousness of the Bangladeshi rural community. Our research also found the evidence of NGO activity facilitating health decision-making.

The aim of this paper was not to establish a cause and effect relationship or even an association between health equity and community empowerment in Bangladesh. Rather, our aim was to explore a reinforcing factor in the pursuit of establishing UHC, and eventually achieving health equity. This study, which was originally a part of a larger study on CPHC, explored the status of community empowerment in Bangladesh. In reporting our findings, we aim to sensitize academia and policy makers to the need to conduct further research to understand the critical factors pertaining to community empowerment in Bangladesh; designing community empowering programs; evaluating the outcome/impact of the intervention; and, finally, formulating evidence-informed policies in this regard. This paper unearthed the unsatisfactory picture of community empowerment in certain domains (inclusion and participation, accountability, and local organizational capacity), and a satisfactory picture in some others (access to information). This piece of information can be useful for policy makers to decide, if convinced, which domains to emphasize in attaining community empowerment. Through qualitative enquiry, this paper conveys community voices in the form of suggestions and demands for their own empowerment. By no means is this an exhaustive list of community empowerment needs, nor do these recommendations function exclusively to further community empowerment, and consequently health equity. However, these can be considered as a basis for taking initial steps towards the epic journey of achieving health equity.

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Figure 1: Pathway of Achieving Health Equity through Community Empowerment

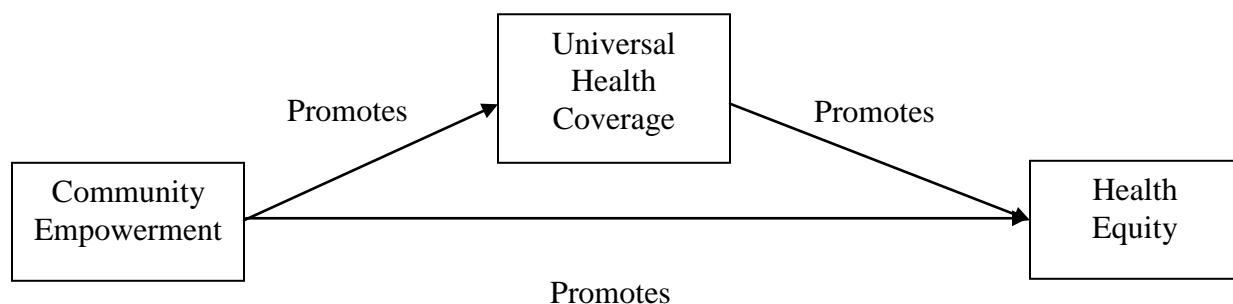


Table 1: Socioeconomic and Demographic Characteristic of Respondents

Characteristic	Aggregated	Kashipur	Charlata
Total Respondents	225	100	125
Number of Males	125	44	81
Number of Females	100	56	44
Mean Age (Years)	41.8	41.1	42.3
Age Group			
Younger (less than 35 years)	70 (31.1%) 118 (52.4%)	33 (33%) 51 (51%)	37 (30%) 67 (54%)
Middle Age (35-50 years)	37 (16.4%)	16 (16%)	21 (17%)
Older (more than 50 years)			
Marital Status			
Unmarried	3 (1.3%)	2 (2%)	1 (0.8%)
Married	226 (96%)	95 (95%)	121 (96.8%)
Separated	6 (2.7%)	3 (3%)	3 (2.4%)
Age of Marriage (Years)	18	17.3	18.6
Family Size (Number)	5.5	5.3	5.7
Educational Qualification			
Illiterate	143 (63.6%) 72 (32%)	48 (48%) 43 (43%)	95 (76%) 29 (23.2%)
Primary (Class 1-5)	7 (3.1%)	6 (6%)	1 (0.8%)

Secondary (Class 6-10)	3 (1.3%)	3 (3%)	0 (0%)
Higher Secondary (Class 11-12)			
Household Income (Taka)	8771.6	14015.0	4576.8
Income Quintile			
Lowest	47 (20.9%)	12 (12%)	35 (28%)
Second	67 (29.8%)	19 (19%)	48 (38.4%)
Third	23 (10.2%)	7 (7%)	16 (12.8%)
Fourth	45 (20%)	25 (25%)	20 (16%)
Highest	43 (19.1%)	37 (37%)	6 (4.8%)
Occupational Profile (Multiple Response Allowed)			
Farming in Own Land	85 (37.8%)	46 (46%)	39 (31.2%)
Agricultural Laborer	18 (8%)	7 (7%)	11 (8.8%)
Day Laborer	47 (20.9%)	16 (16%)	31 (24.8%)
Poultry Farming	4 (1.8%)	4 (4%)	0 (0%)
Dairy Farming	3 (1.3%)	3 (3%)	0 (0%)
Service Holder	40 (17.8%)	21 (21%)	19 (15.2%)
Trade and Business	98 (43.6%)	23 (23%)	75 (60%)
Expatriate Earning Member	42 (18.7%)	32 (32%)	10 (8%)
Other	4 (1.8%)	1 (1%)	3 (2.4%)

Table 2: Use of Mass Media Disaggregated by village

	Kashipur	Charlata
Television	100 (100%)	5 (4.0%)
Radio	0 (0%)	119 (95.2%)
News Paper	0 (0%)	1 (0.8%)

(Pearson Chi-square *P*-value < 0.05)

Figure 2: Mass Media Usage by Income Quintile

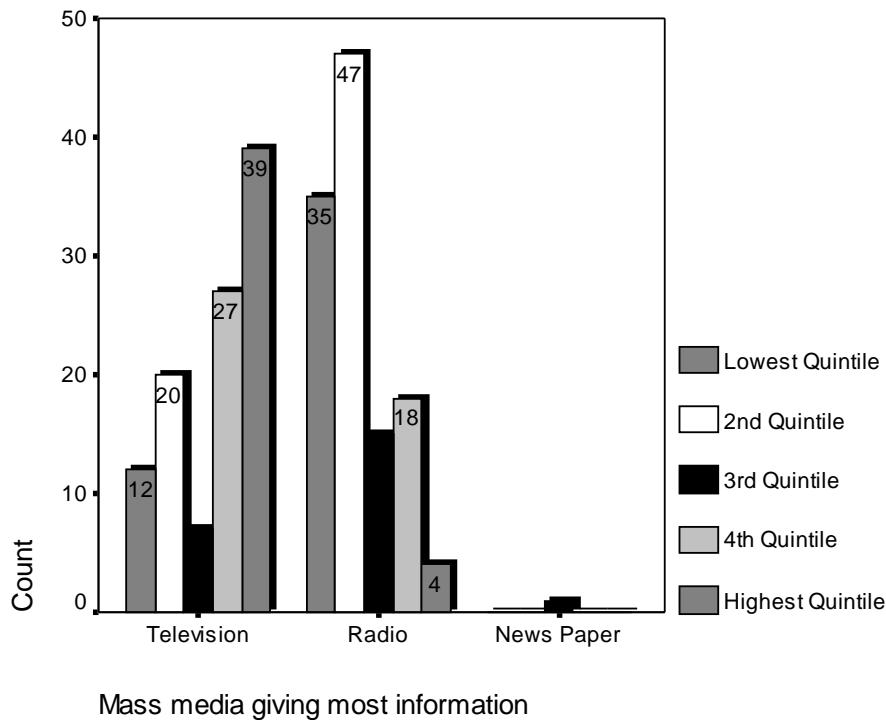


Table 3: Suggested Mechanisms for Client Feedback

Suggestion	Percentage
Government staff visit households to receive complaints	0.4
Installation of a complaint box	6.7
Local government members become involved	0.4
Appoint someone to receive complaints	92.4

A critical player: The role of civil society in achieving universal health coverage

Rebecka Rosenquist, Olga Golichenko, Tim Roosen, and Julia Ravenscroft

This article explores how nascent civil society 'movements' are working towards achieving universal health coverage (UHC), why the involvement of civil society is essential for delivering a universal and inclusive system as well as how the growing number of civil society voices contributing to this debate conceptualise UHC in future global health governance. It focuses on civil society action on UHC at the global level as well as within Ghana, Thailand and Uganda.

Civil society actors are adding their voices to the debates about UHC and this has powerful implications for the success of defining and achieving it. The authors argue that civil society should strive to define UHC and promote it as part of a global movement committed to health equity and solidarity. Further, that coverage should be framed in a forward-looking dynamic manner, recognising human rights and equity, and the need to embed them into global governance.

INTRODUCTION

The right to health must be central to any future global governance framework. A commitment specifically to universal health coverage (UHC) is key to enshrining this aspirational goal into a state obligation that all people will have access to an essential package of quality health services without the risk of financial ruin associated with paying for healthcare. UHC is critical to promoting equity and social cohesion in countries, based on the principle of solidarity with the poorest and most vulnerable communities. Civil society actors are adding their voices to this agenda and this has powerful implications for the success of defining and achieving UHC. As momentum behind UHC as a goal in the next global development framework continues to grow, it is important to understand the critical role of civil society actors, at the national and global level, in shaping this agenda and acting as a watchdog to monitor its achievements.

This article explores how nascent civil society 'movements' are working towards achieving UHC, why the involvement of civil society is essential for delivering a truly universal and inclusive system as well as how the growing number of civil society voices contributing to this debate conceptualise UHC in future global health governance.

As part of the cross-European advocacy network Action for Global Health, we have had a role coordinating work on UHC with civil society globally.¹ A growing informal coalition advocates that governments are responsible for delivering universal access to health with financial risk protection according to their legal commitments to the right to health. This is only possible if national governments and international institutions develop sustainable health financing mechanisms to support strong and equitable national health systems.

Achieving UHC has the strong potential to improve health outcomes, accelerate social and economic growth and contribute to the achievement of sustainable development. Alongside the commitment to UHC in and of itself is the growing

momentum for UHC as part of the global development framework to follow-on from the Millennium Development Goals (MDGs). In the outcomes of the UN's consultation process on post-2015, UHC has emerged as a critical mechanism for delivering improved health outcomes as well as an important goal in its own right.

This article takes a special focus on civil society action on UHC at the global level as well as within Ghana, Thailand and Uganda.

THE ROLE OF NATIONAL CSOs IN ADVANCING UHC

Many developing and middle-income countries that have sought to expand their health service coverage in recent years have seen civil society and communities playing a pivotal role.²

The breadth of organisations, including disease-specific NGOs, that have signed the Action for Global Health Civil Society Call to Action on UHC reveals the potential of UHC for uniting health civil society advocacy and providing a basis for a post-2015 development framework that delivers on health holistically. Alvaro Bermejo, Executive Director of the International HIV/AIDS Alliance, said: "Within the post-MDG framework I would like to see improved health outcomes of the poorest and most marginalised communities globally through the provision of universal coverage and access via a rights-based approach. When UHC is being defined by national governments, it is crucial that prevention, treatment, care and support for people living with HIV are included."³

Through their work with communities, civil society organisations (CSOs) are well-positioned to support the government in the delivery of healthcare and remove the barriers which prevent people's access to health services. James Robertson from India HIV/AIDS Alliance: "UHC in India will only be achieved through systematic collaboration across sectors. Civil society must play an active role, notably to reach marginalized groups."⁴

Thailand is one country that has become well known for its gains on UHC. Before this laudable achievement however, Thai civil society organised itself into an awareness-raising campaign advocating equal benefits for all and produced their own alternative National Health Security Bill which was submitted with the support of thousands of signatures. In this way, civil society was instrumental in securing Parliament's commitment to UHC and the roll-out of the policy, evolving from "an external lobby group into a part of the political process."⁵ Due to this involvement, when the National Health Security Act was enacted in 2002 it had very strong support from civil society.

In Uganda, CSOs have been coming together, to engage the government to ensure that quality health care services are provided to the marginalised and poor citizens of the country such as women and people living with HIV/AIDS. Dennis Odwe of the Action Group for Health, Human Rights and HIV/AIDS, said: "CSOs are invited to make presentations before the budget and social services committees of parliament on what the government should do differently to provide quality health services."⁶

However, the Action Group for Health, Human Rights and HIV/ AIDS also highlights problems CSOs face in Uganda, including restrictive laws that hinder their role to build state accountability, such as restrictions on freedom of assembly and expression. He said: "CSOs should continue with advocacy towards UHC. More capacity building is needed though for CSOs to understand the issues around UHC."⁷

How CSOs can Shape a Global Movement to get UHC in the Future Global Health Governance Agenda

At the global level, there is room for greater coordination amongst health-related civil society on UHC, and Action for Global Health is starting to play this role in Europe. A truly global movement would bring value, pushing this agenda from one solely on national responsibility to one of global solidarity. South Africa's announcement of National Health Insurance provides an important example of the global aspect of this agenda and South-South learning as they were influenced by Brazil in this process. International NGO networks and partnerships are, and should be, a key component in fostering these links.

There are differing viewpoints on UHC and how this is defined. The authors of this article, and many of the civil society partners that we work with, see this as a continually evolving debate.

The main areas of concern – and areas where civil society has an important role to play are:

- Countries should not be able to claim an achievement of UHC without having a truly universal system in place, including reaching the poorest and most marginalised. Mexico has been lauded for reaching UHC, and has hugely expanded its reach, but clinics can still be very poor in rural areas and some long-term conditions are still not covered.⁸ Gerardo Cabrera from the Mexican Network of People Living with HIV/AIDS, echoed these concerns when he said: "There is a big risk in Mexico that the law on UHC will not help to address the lack of the universal access to treatment for people living HIV/AIDS."⁹
- The goal of achieving UHC cannot only be about health financing, but rather has to address a broader definition of UHC to include removing other (non-financial) barriers, such as stigma and discrimination, which often prevent from accessing the services and have the detrimental effect on the social determinants of health.
- UHC should be built on inclusive participatory processes, engaging CSO's at design, implementation and monitoring of Health Coverage system.

In looking at the position that UHC could have in the next global development framework, the UN System Task Team on the Post-2015 UN Development Agenda raised the concern that UHC "...frames health purely in the context of health services. This misses the point that health is an outcome of policies in many other sectors."¹⁰ As the post-2015 debate has progressed, the option emerging from the UN's thematic consultation on health is that the UHC contributes to the achievement of a goal framed around maximising healthy lives and life expectancy.

It is possible to define UHC in such a way so as to address many of the concerns from the UN System Task Team. An example of a broader definition of UHC comes from India's High-Level Expert Group on UHC. In their report assessing India's progress on achieving UHC they state:

UHC...moves beyond 'insurance' by providing an 'assurance' of healthcare for multiple needs and includes health beyond healthcare.....UHC should address health in all of its dimensions and emphasise prevention and primary healthcare,

which are ignored, neglected or even undermined by the usual systems of health insurance. Such an assurance has to be provided by the government, which has to act as the guarantor of UHC and ensure its success and sustainability, by mobilising all societal resources and advance multi-sectoral actions. In this perspective, the UHC is linked firmly to the Right to Health.¹¹

A new health development goal needs to build on the recognition of health as a human right, and the need to embed this into global governance. Looking ahead, we need a truly global commitment to achieve UHC in the context of the next global development framework. We need solidarity and all actors have a role to play, including civil society. UHC will deliver for health on national levels only if it goes hand in hand with global solidarity, particularly in light of some of the difficulties CSOs face, such as the restrictions on freedoms mentioned in relation to Uganda. Without this the poorest and most vulnerable could be left out on the path to achieving UHC.

Additionally, donor governments and multilateral development organisations, through their official development assistance (ODA), have a potentially powerful role in accelerating national movements towards UHC. They should also seek to fill the financing gap as countries move towards achieving UHC. It is worrying then that many donor countries are cutting their development budgets¹² and deferring to the line that UHC is not an ODA issue. Countries should also be looking at vital alternative financing generating mechanisms such as the Financial Transaction Tax (FTT). The World Health Organisation needs to be properly funded and strengthened so that it can play the pivotal role of providing technical assistance to countries that are moving towards UHC.

Looking forward, through an inclusive and open process, civil society should strive to define UHC and promote it as part of a global movement committed to health equity and solidarity. One ambitious example of the role of UHC in future global governance structures comes from the academic research network *Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI)*. They have developed their own position on UHC in the post-MDG agenda and how it could include key principles that would lay the groundwork for a legally binding Framework Convention on Global Health in the future.¹³

Action for Global Health, as a European network with global reach, will itself play a convening role within civil society to further define its position on UHC. It will continue to engage with the UN process to define the next global development framework, including by working with the important civil society platform Beyond 2015, and address the Member States on their responsibility to ensure the right to health. A commitment to UHC in this framework needs to be defined in such a way that countries cannot achieve a certain minimum and then consider themselves to have achieved the goal. Coverage should be framed in a forward-looking dynamic manner, recognising human rights and equity, and the need to embed them into global governance.

A CASE STUDY: GHANAIAN CIVIL SOCIETY INVOLVEMENT IN QUESTIONING AND RESHAPING THEIR HEALTH SYSTEM

The Ghanaian campaign for UHC was launched following the implementation of the Ghana National Health Insurance Scheme (NHIS) in 2003, when complaints about access, quality of healthcare, equity and coverage began to emerge. A number of civil society actors came together in a research consortium in order to better understand the realities on the ground. Their 2011 report concluded that the coverage of the scheme nationwide had been hugely exaggerated and could be as low as 18%. It also found that those excluded from the NHIS were still being forced into poverty by paying user fees in the cash and carry system.¹⁴

The report led the Ghanaian campaign to conclude that “the scheme in its current form could not guarantee Universal Access to Healthcare, and that there was the need to abolish the annual premiums and adopt tax based financing alongside other innovative financing mechanisms, to ensure that the poor and marginalised have universal access to basic healthcare in Ghana.”¹⁵

The campaign demonstrated their strength and legitimacy when Ghana’s delegation to the World Bank and World Health Organisation’s ministerial meeting on UHC in February 2013 was forced to concede that the figures in their report were correct and that they have a way to go to expand the percentage of the population covered by the NHIS in line with their official aims.¹⁶

The Ghanaian campaign, with more than 200 CSOs involved, shows the unifying power of UHC as it is comprised of a number of organisations ranging from the national association of people living with HIV and AIDS, to the Alliance for Reproductive Health Rights, to the Ghana Federation for the Disabled, ISODEC and the Coalition of Health.

Rebecka Rosenquist from Plan UK is a member of the Action for Global Health network.

Olga Golichenko from the International HIV/AIDS Alliance is a member of the Action for Global Health network.

Tim Roosen is the Coordinator of the Action for Global Health network.

Julia Ravenscroft is the Project and Communications Officer for the Action for Global Health network.

With thanks for the contribution from Hor Sidu, who is the national coordinator of the Universal Access to Healthcare Campaign.

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Universal Health Coverage: Setting Global and National Agendas

Viroj Tangcharoensathien, David Evans, and Robert Marten

Based on various momentums, the World Health Assembly 64.9 in 2011, had moved Universal health coverage (UHC) from the Geneva-based Health Ministers discussion at the World Health Assembly to a New York-based United Nations General Assembly discussion led by Heads of State and Ministers of Foreign Affairs. This paper analyzed the processes for which UHC agenda was set at global and national level. At global level, the seven like-minded countries in the Foreign Policy and Global Health group, in consultations extensively with all missions in Geneva and New York managed the unanimous adoption of UN General Assembly Resolution A/67/L.36. At national level, adopting UHC agenda is as challenging as implementing it with a good outcome; strengthening health delivery systems and sustained political commitments are vital.

Universal health coverage (UHC), defined as the situation where "all people have equitable access to health services and do not suffer financial hardship paying for them," is increasingly advocated as an important objective of health policy at global and national levels.¹ The first global recognition of its importance was in a 2005 World Health Assembly resolution (58.33), which urged countries to develop their health financing systems in ways that could move them closer to UHC.² Some countries took active steps in response, but the 2010 World Health Report on *Health Systems Financing: The Path to Universal Coverage* increased the attention given to UHC as a goal for health policy. The report drew on country experiences to show that countries at all income levels could move more rapidly towards UHC with the appropriate political will.³

The momentum since 2010 has been considerable. The World Health Assembly adopted another resolution in 2011 (64.9) which not only urged countries to make progress in terms of their health financing systems but also elevated the discussion to the global level by requesting the Director-General of WHO "to convey to the United Nations Secretary-General the importance of universal health coverage for discussion by a forthcoming session of the United Nations General Assembly".⁴ Through this statement, WHO Member States recognized the goal of achieving UHC required broadening support beyond a Geneva-based health ministers' discussion at the World Health Assembly to a New York-based United Nations General Assembly discussion led by heads of state and ministers of foreign affairs. Achieving UHC goals goes beyond the conventional mandate and jurisdiction of health ministries: most importantly it requires full engagement by heads of state to marshal a concerted effort across ministries, private sector and civil society.

Beyond the health ministry, multiple ministries must be involved. Labor ministries are responsible for social protection of workers, often including health insurance coverage to at least part of the population, something reflected in a number of ILO Conventions.⁵ Ministries of social welfare are responsible for social protection for the poor, the vulnerable, and sometimes the informal sector. Finance ministries determine budget allocations to the different sectors and fiscal space for health, and international commitments such as those in the Abuja Declaration of 2001, where

African Union Heads of State promised to allocate at least 15% of annual government budgets to health, cannot be achieved without the involvement of finance ministries - and Heads of State.⁶ Planning ministries or their equivalent, work across sectors and with development partners, ensuring effective coordination across government and donors in line with Paris Declaration principles.⁷ Finally, the inclusion of UHC as an international development goal or objective cannot happen without the involvement of ministries of foreign affairs at the international level.

In January 2012, Prince Mahidol Award Conference in Bangkok, entitled *Moving Towards Universal Health Coverage: Health Financing Matters*, further stimulated momentum. Six health ministers endorsed the Bangkok Statement calling for raising the profile of UHC on national, regional, and global agendas. It included a call to bring UHC to the agenda of high-level meetings related to health or social development including to the UN General Assembly, and to promote its inclusion as a priority on the global development agenda.⁸ In April 2012, a Mexico City Political Declaration on Universal Health Coverage was endorsed by a number of other ministers of health.⁹

The most recent World Health Assembly Resolution and the Bangkok Statement elevated UHC to the global, multi-sectorial agenda, urging engagement and commitment by heads of state in the United Nations General Assembly. The Mexico Declaration further interpreted UHC as an important element in the international development agenda that needed to be included in international development goals and targets. It argued that UHC promotes sustainable growth, social cohesion and population well-being, an idea subsequently taken up by the UN Conference on Sustainable Development held in Rio de Janeiro in June 2012.¹⁰

In May 2012, Dr. Margaret Chan, in her reappointment as Director General of WHO by the 65th World Health Assembly, stated that UHC was one of her flagship concerns for the next five years.¹¹ More than 100 countries spoke in the first plenary debate on the topic of UHC ever held in the World Health Assembly; there were also a variety of side meetings and technical discussions sharing experiences across Member States and civil society organizations about how to move the UHC agenda forward.

An important question becomes how best to ensure UHC is reflected in forthcoming international development goals in a way that supports country actions. One possibility currently under discussion is to consolidate UHC momentum with a UN General Assembly resolution. The contrasting experiences of road safety and non-communicable diseases (NCD) in the UN offer important insights on how to do this. Since the 2003 global road safety crisis report submitted to the UN Secretary General, there have been five UNGA Resolutions on the topic: UNGA Resolution 58/289 in 2004, 60/5 in 2005, 62/244 in 2008, 64/255 in 2010, and 66/L43 in 2012. Despite this, reviews of various UNGA resolutions shows slow progress in improving road safety in many countries.

In contrast, there have been only three UNGA Resolutions on NCDs. The first Resolution (64/265) adopted in May 2010 decided to convene a high-level meeting of the General Assembly in September 2011 on the prevention and control of NCDs, importantly with the participation of heads of state. The second, Resolution 65/238 of April 2011, outlined the scope, modalities, format, and organization of the High-level Meeting. The third, Resolution 66/2 of September 2011, adopted the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs.¹² Within two years, there was rapid progress in translating the political

declaration into a global plan of action, with a proposed monitoring framework, targets, and indicators to be presented at the World Health Assembly in 2013.

Learning from these two experiences, a group of like-mind countries - including seven countries in the Foreign Policy and Global Health Group¹³ championing UHC from Europe, the Americas, Asia, and Africa – are proposing to submit a draft resolution to the United Nations General Assembly for consideration before the end of 2012. Among other things, it will call for a High Level Meeting of heads of state on UHC to be convened by September 2014. These countries expect that the meeting would produce a framework supporting countries' efforts to move towards UHC as well as contribute to the discussion of how UHC – a key component of sustainable development - could be incorporated into any development goals that might emerge in the post-MDG era.

This would build on the work of the recent UN Conference on Sustainable Development, commonly called Rio+20.¹⁴ After intensive inter-country negotiation, consensus was reached to include UHC in six of the 283 paragraphs of the proposed UNGA Resolution A/66/L.56. UHC was recognized as enhancing social cohesion and sustainable human and economic development (paragraph 139) while at the same time being important for improving health including for specific diseases and conditions such as HIV (paragraph 140), NCDs (paragraph 141) and reproductive health services (paragraphs 145, 146 and 241). Through this, UHC has already been accepted in an important UN meeting as one of the important instruments for ensuring sustainable human and social development, which can form the basis of subsequent discussions in the UN General Assembly.

The links between UHC and sustainable development are clear: inadequate access to needed health services, particularly by the poor, pushes people into poverty or deepens poverty because people cannot work and earn a living. Children cannot continue schooling. At the same time, people suffer financial hardship or are pushed into poverty because they need to pay for health services. The attention of heads of state to this issue in the UN, as well as the inclusion of UHC in any internationally agreed development goals and targets would facilitate country efforts to move forwards more rapidly.

We acknowledge, however, that effective UHC implementation at country level is frequently challenging. In many countries, it will require significant increases in public spending on health (prevention, promotion, treatment, rehabilitation) as well as improved capacities of the health system to deliver these political promises.

It is evident from the MDG tracking process that weak health systems are a major reason why many countries are struggling to achieve the MDG health targets by 2015 and translating political promises made in the UN or other forums to reality at a country level is not straightforward.¹⁵ One prominent example is the failure by numerous sub-Saharan African countries to meet their Abuja promises over the last ten years. Similarly, many of the countries that signed the 2008 Kampala Declaration¹⁶ to improve access to needed health workers, including some of the 57 priority countries identified as having a critical shortage of health workers,¹⁷ have made little progress in addressing the problem. Not surprisingly, in many of these countries coverage of immunization and other maternal and child health services is low and the availability of domestic funding and fiscal space, measured by the ratio of tax receipts to GDP, are below the levels necessary to achieve UHC.¹⁸

Improving health delivery systems is critical, requiring not just health workers, but medicines, appropriate technologies, health facilities, information systems, and good governance. Increased resources are critical too. Favorable economic growth facilitates governments raising and spending additional funds on health given strong political commitment. So can re-prioritization of health within the government budget; increases in health-specific grants and foreign aid; and other ways of raising additional funding such as “sin taxes” or the introduction of mandatory health insurance. Improved efficiency of health outlays in both government and private sectors are also important in ensuring more health for the money.¹⁹ As reported in the World Health Report of 2010, various low and middle income country experiences suggest this is feasible.

For example, Thailand demonstrated two parallel streams of health systems development starting in 1970,²⁰ which were the foundations of its achievement of UHC in 2002. First, extending geographical coverage of primary health care to the sub-district and district levels where the rural population had better physical access to services was important along with an effective referral system for back-up tertiary care. This was combined with mandatory rural service by new graduates in all health professions from 1972 as a way of ensuring health workers were located close to people. Second, the gradual expansion of financial risk protection to the poor started in 1975 with targeting specific groups of the population, culminating in the 30-Baht scheme of 2002.²¹ The Thai experience suggests that a universal financial risk protection system in health needs to be built on comprehensive geographical coverage of good quality primary health care services.²²

To achieve UHC in both its senses – coverage with needed health services and coverage with financial risk protection - it is fundamental to strengthen the health delivery platform at primary care level, ensuring these “close-to-client” services are well functioning with adequate medicines, appropriate medical diagnostics and treatment, and staffed by an adequate number of motivated and responsive health workers. While several countries have shown that UHC is not an impossible dream, it will be a long, never-ending quest as health problems change, populations age, and new, more expensive health technologies become available. Though a UNGA resolution may not guarantee success at the country level; it would increase the focus on UHC and continue the growing momentum of political commitment. Indeed, continued success will depend on sustained political commitment, improved health system capacity, and a measurable framework for monitoring UHC progress.

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GLOBAL HEALTH GOVERNANCE

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Global Governance for Universal Health Coverage: Could a Framework Convention on Global Health Hold it Together?

Claire E. Brolan, Jonas Hill, and Peter S. Hill

Since their development in 2000, the Millennium Development Goals have substantially influenced global health governance, their indicators now forming an accepted metric for the measurement of global and local progress towards health, and against poverty. With post-2015 development goals now being debated, the World Health Organization and key stakeholders have advocated for Universal Health Coverage (UHC) as the primary health goal, though support has been equivocal, in part due to a lack of consensus on its definition. Despite this, UHC does offer a necessary operative structure within which the ultimately selected post-2015 health goals could be operationalized. For this to occur, the meaning of UHC will need to be secured in a global health governance context. This paper argues that a Framework Convention on Global Health, acting as a “point de capiton”, may achieve this, stabilizing the discourse on UHC around which structures of global health governance may be organized.

INTRODUCTION

Proposed in 2007 by Professor Lawrence Gostin, a Framework Convention on Global Health (FCGH), with the right to health at its core, is garnering global attention.¹ In their June 2013 Introduction to the Special Issue on ‘Realizing the Right to Health Through a FCGH?’ in *Health and Human Rights: An International Journal*, Friedman et al. discuss three ways that a FCGH could surmount the key problems of standards, funding and governance miring global health today: First, by clearly setting out standards aimed at enabling health for all through equitable and effective health systems and socio-economic conditions required for good health; second, by establishing a financing framework to achieve predictable and sustainable funding for global health; and third, by entrenching good governance mechanisms to promote transparency, equity and accountability within and among states and other relevant actors.² The FCGH charts an ambitious agenda: promoting priority-setting and redressing health disparities experienced by marginalized populations. In seeking to overcome global health fragmentation, it offers a mechanism for bridging the formal structures of global governance and the complex network of information, discourses, and alliances that tether diverse global actors not bound by the United Nations (UN) system. While respecting our colleagues’ commitment to this ultimate claim, this paper argues for a more modest and incremental—though still substantial—initial role for a FCGH.³ We argue that the Framework Convention could demonstrate its utility by providing a structure through which global governance of Universal Health Coverage (UHC) might be achieved, binding donors and partner countries to ensure predictable, sustainable resourcing for health, ensuring consensus on outcomes, and preserving local diversity and ownership in the achievement of universal access and coverage of health systems.

Despite the apparent displacement of UHC from its anticipated primacy as the 'umbrella' health goal for the post-2015 development negotiations, there remains considerable support for UHC among Member States, the World Health Organization (WHO) and other key actors.⁴ Clearly, UHC will remain on the table.^{5,6,7,8,9,10} The still-to-be-decided post-2015 development goal(s) for health may provide an alternate focus for global attention, but will still require a health systems framing for implementation. The one health goal among the twelve illustrative goals in the High-Level Panel of Eminent Person's post-2015 development agenda report (Goal 4 – Ensure Healthy Lives) embraces five targets.¹¹ These are essentially an iteration of the unfinished business of the health-related MDGs, adding Neglected Tropical Diseases and selected Non-Communicable Diseases. As in the previous goals, these are framed in a vertical, targeted approach; necessary but not sufficient to deal with the heterogeneity and complexity of issues in the unfolding global health landscape.¹² The filter of the sustainable development agenda—yet to be fully engaged by the global health community—adds a further layer of complexity. As WHO concedes: "while a new generation of goals offers a means of measuring progress across the economic, social and environmental pillars of sustainable development (and health is well suited to do this), institutional arrangements at a global level for ensuring such policy coherence remain weak."¹³ The FCGH offers the most appropriate mechanism to bridge this global governance divide, as negotiating this daunting disease focus through the post-2015 goal process will require a health systems framing for delivery, which the provisions of an international treaty can explicitly sustain.

The challenge for the global health community is to now develop—and sell—a convincing framework that can rise to post-MDG health and development challenges (and meet fresh health agendas including non-communicable diseases, mental health, environmental health in a broader public health context, pandemic preparedness) while strategically accommodating the complexity of global governance for health that comprises the multiple stakeholders, agendas, budgets, networks and relationships that have evolved (and are evolving) in response to MDG health initiatives.^{12,14} The framework needs to be able to synchronize the increasing fragmentation of global health governance, but preserve its creative diversity and local autonomy. Ensuring that this new framework will have genuine political support for its compliance mechanisms, as well as civil society and private sector endorsement, will be key. This article will therefore explore the potential link between the FCGH and global governance for UHC, intersecting with the new health-related development goals. In doing so we recognize the imperative for UHC as the necessary structure within which any post-2015 health goals or targets will be operationalized. We argue that a FCGH may have the bold, transformative potential and positioning to provide a discourse for reforming global obligation around which structures of global health governance may be organized.

THE WORLD SINCE THE MILLENNIUM DECLARATION – CHANGES IN GLOBAL HEALTH GOVERNANCE

Since the MDGs were initiated in the early 2000s, the world has witnessed *profound* global change. This change has synergistically impacted—and been impacted by—dynamic changes in the global health landscape. Notably, "exceptionally rapid globalization" has transformed "the field of international health that had taken shape in

the mid-twentieth century into the field of global health that we encounter in the early twenty-first century.”¹⁵ The shift from international to global health also reflects the enormous growth in new actors, networks and mechanisms in health (and inter-related development sectors) that have crystalized in response to the MDG agenda.^{16,17} The unprecedented increase in stakeholder growth is further propelling global health funding: in under two decades, development assistance for health has seen a 400% increase (from US\$5.6 billion in 1990 to US\$21.8 billion in 2007).¹⁷

Powerful non-state actors, together with other international organizations, non-government organizations (NGOs), and a diverse array of individuals who are not government leaders (from Bono to Jeffrey Sachs) have brought new money (or new initiatives for raising money), new partnerships, and, significantly, new global health agendas. Juxtaposed with this is the recognition of newly emerging donor countries such as Brazil and China, with their own set of motivations, assumptions and discourses.¹⁸ Over 100 multi-stakeholder Global Health Initiatives (GHI), generally more disease focused in response to the health challenges prioritized in the MDGs, also vie for global health influence with considerable fiscal force.¹⁹ The United States President’s Emergency Plan for AIDS Relief (PEPFAR) has added a new dynamic to more traditional bilateral development assistance, and bilateral agencies such as the UK’s Department for International Development (DFID) and those of Scandinavian governments engage increasingly in networks and partnerships that extend their national influence in the new global governance for health.

The UN, meanwhile, sits uncomfortably at the global health governance juncture between the system of sovereign states from which it derives its legitimacy, and the complex of transnational networks and partnerships that effectively shape the global health agenda.²⁰ The UN itself is increasingly pluralized, with bodies such as WHO, UNICEF, UNFPA, and UNAIDS maintaining distinct and independent positions in health, and other supranational organizations, including the World Bank, World Trade Organization, and International Monetary Fund increasingly exercising engagement in health issues. New, inter-related forums have also been created, such as the Health 8 (H8), with UN health agencies combining with the World Bank, GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and the Bill and Melinda Gates Foundation to harness their combined public-private influence as a counterpoint to the G8.²¹

This century’s emerging global health governance has alternatively ensured that “calls for better *coordination* of aid are almost as common as calls for more aid,” with multiple -- and competing -- mechanisms emerging to manage the necessary coordination.²² The Paris Declaration on Aid Effectiveness in 2005 affirmed “the necessity for the donor community to march towards common goals” and represented “a crucial landmark on the path towards coherence.”¹⁸ Yet donor implementation of the Paris Declaration’s targets has been “highly uneven.”²³ The 4th High Level Forum on Aid in Busan, Korea, began to engage a more complex diaspora (including South-South assistance, Middle Eastern donors, and BRICS nations).²⁴ However, the recognition of this greater diversity simply exposes the anachronisms implicit in current mechanisms for coordination and their dependence on a Westphalian imagining of governance. The necessary instruments to engage this growing complexity will, in themselves, be incredibly diverse, creating a governance matrix that combines rules, norms, incentives

and agreements, information, discourses, networks and alliances that tenuously hold together disparate players in global health in a series of global forums.^{18, 25}

UNIVERSAL HEALTH COVERAGE: A NEW FRAMEWORK FOR GLOBAL HEALTH

Within this contemporary global health governance, the MDGs have played a significant role in managing this hybrid complexity, uniting UN structures with a range of other players—global public-private partnerships, private philanthropies, and elements of civil society—in the acceptance of the MDGs as mechanisms for setting global directions and as a metric for the measurement of global development.²⁶ For health, however, this has occurred in narrow ways—in child health, maternal health, HIV/AIDS, Tuberculosis (TB) and malaria: the MDGs were so specific as targets that they narrowed the extent of engagement available, even though they brought enormous resources and attention to the specific goals themselves. And the health goals, with their specific targeting of selected populations and diseases, simultaneously promoted an understanding that good health equates with provision of, and access to, targeted health care services for particular population groups—chiefly located in low- and middle-income countries—where the afflictions of child and maternal morbidity and mortality, HIV/AIDS, TB and malaria are more likely found.

The MDGs' presentation of health (namely in three discrete global goals) is in tension with the inclusive, yet broader global imagining of health that WHO has put forth for some time (especially under Margaret Chan's leadership) and has recently raised to stimulate post-MDG discussion.^{27, 28} WHO recognizes, despite local and regional priorities, that, "there is a global desire to develop international strategies to improve healthcare" and achieve health for all (as opposed to the disease and population specific MDG health agenda).²⁹ It follows that for many global health players, the health-related development agenda post-2015 must be centered on UHC and its link to WHO's revitalization of Primary Health Care. While UHC does offer something more substantial in breadth than the MDG silos, it nevertheless has lacked fixed meaning. It has not been clear what health services UHC covers, and questions arise over whether UHC includes only services in the health sector or services and interventions outside the health sector (but still within sectors located inside the state).^{30, 31} Multiple meanings of UHC circulate: UHC as national service delivery; UHC as national service coverage; UHC as national health insurance coverage; and UHC as accessible, quality services. We agree with Fan, Glassman and Savedoff that "lack of consensus around the technical work" of UHC has served to "inflame rather than address ideological debates."³¹ Compounding this tension is that UHC is frequently described in public and global health circles as "utilization of health-care services" and "rights to health care financial protection" for citizens who reside within a state's borders; such state-centric positioning of UHC is increasingly confusing in light of the post-2015 global health debate in which WHO and others appear to be advocating for a 'globalist' rather than 'statist' definition of UHC.^{32, 33} In other words, these traditional state-centric meanings and applications obscure the potential of a UHC redefined towards a more global (and indeed, literal) positioning.³² There is a risk that UHC may devolve from a global aspiration to a national, state-centric accounting, as has in part occurred with the MDGs.³⁴ Yet while global consensus needs to be preserved around our aspirations for health systems' values and health outcomes, local ownership and the necessary diversity

within health systems implementation in multiple social and cultural contexts also needs protection.

The real danger in the uncritical acceptance of UHC as the default position for health in the negotiations towards the post-2015 development goals is that it signifies divergent, but very specific meanings for its disparate advocates, ranging from the instrumental (universal health insurance) through to universal coverage of health services (with a range of service 'packages') to rights-based comprehensive entitlements. However, while UHC as currently debated may not be ideal in itself, we need a framework that adequately defines the concept, providing a workable consensus for UHC while stitching together the multiple understandings of UHC into one richer, more dynamic all-embracing cover. This may not be possible within the constrained format of the post-2015 development goals as the global debate is framing them. In fact, UHC reduced to a slogan, or to a composite (but one dimensional) metric, would be counterproductive. The UHC complex needs something that complements the goals process in order to ensure that the richness and dynamism of the concept, is preserved. This tension—between the stable and the adaptive—is what generates the momentum for an array of different stakeholders to engage, and re-engage with it as it evolves over time.

FRAMEWORK CONVENTION ON GLOBAL HEALTH: SECURING AN EXPANDED UNDERSTANDING OF UHC

One option offering the combination of global structure and flexibility necessary to support UHC is a FCGH. While the content of this potential treaty remains subject to debate, Gostin envisioned its terms would set "achievable goals for global health spending as a proportion of GNP; define areas of cost effective investment to meet basic survival needs; build sustainable health systems, including trained health care professionals, surveillance, and laboratories; and create incentives and systems for scientific innovation for affordable vaccines and essential medicines," with the WHO "or a newly created institution..."³⁵ setting ongoing standards, monitoring progress, and mediating disputes. However, in this era of regime complexity mixed with post-2015 hyperbole, it remains unclear whether the international community of states would have either the energy or appetite for Gostin's (undoubtedly time intensive and expensive) global health treaty.³⁶ Certainly even if there was interest, it remains to be seen whether states could come to consensus on the treaty's terms, especially when a number of potentially contentious provisions are already being advocated for insertion and questions surround the Framework Convention's justiciability.^{37,38,39,40,41}

Indeed, Hoffman and Rottingen, applying Kennedy's exploration into the "dark side" of seemingly virtuosic and honorable international human rights law pursuits, warn of the proposed FCGH's shadow.^{42,43} They point to its potential duplication of other human rights documents and governance mechanisms, arguable lack of feasibility in terms of both state negotiation and implementation, and questionable ability to effectively redress global health inequities. We recognize Hoffman and Rottingen's (and others) concerns, but argue that if the first focus of the Framework Convention was initially directed towards UHC, which is "a practical expression of the concern of health equity and the right to health," this incremental but still substantial approach could well generate a groundswell of state interest and challenge global sceptics.^{13,44,45}

Neither do we share Gostin's anxiety that an incremental process—the focus of UHC initially underpinning the Framework Convention—would stymie momentum and be a barrier to implementation.^{1,35,46,47} We argue this measured approach could, conversely, rally long-term state commitment to the FCGH and the development of subsequent protocols. This is particularly so, given that UN Member States (including, significantly, the United States) expressed widespread endorsement of UHC, supporting the UN Resolution on Global Health and Foreign Policy in December 2012, which urged governments to move toward providing affordable access to quality health-care services to all people by embracing UHC. The resolution, securing global prominence for UHC regardless of the post-2015 development agenda's reckoning on health on January 1, 2016, emphasized the intrinsic role health systems and universal coverage play in achieving the sustainable development goals, and consequent links to states' foreign policy agenda.⁴⁸

Furthermore, framing the FCGH around a recognized agenda such as UHC could go some way in mitigating Gostin's other (rightful) concern that "negotiation of a multilateral treaty involving resource distribution from rich to poor states would face political obstacles that limit its prospects of success".⁴⁹ Rather, prospects of success could be enhanced as Member States have already supported the Global Health and Foreign Policy Resolution promoting linkage of UHC to "other foreign policy issues, such as the social dimension of globalization, inclusive and equitable growth and sustainable development".⁴⁸ Therefore, the step to cementing this commitment in fiscal terms within a global health treaty may not be so much a giant leap for states as opposed to a hop. This brings us to our next point: the evolving intersection between universality and the post-2015 development goals (allowing states to negotiate differentiated, country-specific targets) may not be best placed to advance the pressing development needs of (and global attention on) lower income countries. This is particularly of concern in those states which have done least well in achieving the MDGs, and are most dependent on external support to maintain progress on their unfinished MDG business before addressing the post-2015 sustainable development agenda. In fact, if the post-2015 development goals are to follow the silo approach of the MDGs, crucial health systems strengthening and whole-of-government strategies to address the underlying determinants of health will be sidelined from both internal and external focus and resource in favor of addressing narrow, disease-specific targets. However, a FCGH with firm inter-governmental funding commitments for health and development encapsulated in a more tangible UHC could be better placed to meet the realities and interests of lower income countries—a far more attractive alternative in overcoming country inequities and realizing the human right to health (and interconnected rights) for all.

Smyth and Triponez argue that the "templates available under the umbrella framework could be devised using a mix-and-match approach that borrows liberally from different aspects of precedent initiatives that reflect best practices".⁴¹ In our analysis for this proposal, the International Health Partnership Plus (IHP+), launched in 2007 to progress the 2005 Paris Declaration of Aid Effectiveness in the field of health, already offers a template for collaboration around health systems strengthening, and the Global Fund a precedent from which a model for sustainable financing might be extrapolated.^{50,51,52,53} The threat of duplication could be avoided by building on the premise of the IHP+ compacts and its existing 26 signatories, combining the

multilateral funding model of the Global Fund with the commitment of a Framework Convention to provide provisions for sustainable long-term financing, the key ingredient for impact feasibility not currently available to IHP+. Consistent with the IHP+'s focus, the Framework Convention would bring donors together by codifying a consensus aspiration to guarantee access to affordable, accessible quality care globally, yet flexible enough to allow country diversity and country ownership (while targeting those marginalized and most in need). This would enable the post-2015 sustainable development process to proceed while maintaining the focus on those countries least able to fund their systems and most vulnerable to the transition.

The proposed FCGH offers a mechanism for addressing this institutional weakness, at the same time bridging the formal structures of global governance and the network of information, discourses, and alliances that tether the burgeoning array of global actors not bound by the UN system. It offers the opportunity to hold together the layers of meaning implicit in the multiple definitions of UHC in a quilting stitch—what Lacan terms a “point de capiton” (the name suggests the buttons which hold together loose mattress stuffing)—that secures vital elements of the concept, while maintaining sufficient flexibility to allow an ongoing evolution within that frame of meaning that provokes the “desire” of stakeholders and their continuing engagement.^{54,55} The ambiguity that has surrounded UHC points to Lacan’s contention that language at all levels is characteristically ambiguous, and that communication is only possible to the extent that the meaning of complex concepts is held together by an imagining of consensual understanding.⁵⁶ Clearly, within the current post-2015 debate, there are already numerous concepts in operation—maximizing healthy lives, finishing the MDG agenda, and leaving no one behind—each of which is capable of mobilizing support, advocacy, and the emotive “desire” that is produced through their discourse. UHC, without the stabilizing framework of a FCGH, risks only appearing to fix meaning while, in fact, introducing further ambiguity into the debate. Competing with the alternatives is not simply a matter of suggesting a more logical alternative: if the FCGH is to act as a “point de capiton” for UHC, and through UHC to “reimagine global governance for health,” it needs to mobilize a power beyond language in a way that captures and reshapes the global imagining of health.⁵⁷ That dynamic will need to be continued in order to preserve this function of holding the diverse elements of UHC together: and allowing the exploration of local solutions, adapted to local contexts while committing to global outcomes, may be sufficient to maintain ongoing drive.⁵⁶

We argue the Framework Convention’s potential to achieve this arises for three reasons. Firstly, its grounding in the right to health definition provided by the Committee on Economic, Social and Cultural Rights in 2000 inherently underscores and aligns with both UHC and development agendas.

Secondly, a Framework Convention offers a solid framework, a mechanism, that has real potential to set priorities in global health and sustainable development, clarify national and international responsibility, ensure accountability, develop corresponding institutions (such as a Global Health Fund), and incorporate compliance mechanisms on treaty implementation (including sanctions and incentives).⁵⁷

Thirdly, we cannot locate any other proposed mechanism that has the comparable capability--and potential flexibility--to implement the various post-MDG desires of the global health community while also explicitly incorporating measures seeking to improve global health governance. It has the potential to act both as a binding

treaty and a flexible approach, “allowing states to agree to politically feasible obligations, saving contentious issues to later protocols.”⁵⁸

As Gostin himself imagined, “A FCGH would represent a historical shift in global health” by acting as the “innovative international mechanism” to bind States, and others, to collectively respond to ameliorate the enduring and complex problems of global health.³⁵

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A Special Role for the World Health Organization in the Creation of a Living, Breathing Global Health Governance Constitution

Matthew Hoisington

This article argues for a “living, breathing” Global Health Governance Constitution, which would be initiated by a World Health Governance Forum (“Forum”) convened by the World Health Organization (WHO). The content of the new constitution would result from the contributions of the various public health actors. A “Board of Editors,” consisting of officials from the WHO and other stakeholders, would then review contributions and produce a non-binding instrument or modus vivendi. This instrument would be subject to continuous review, with “special temporary revisions” and “opinions” produced on a rolling-basis by the Board of Editors based on open-source contributions and comments submitted by stakeholders. Every year, the Forum would reconvene to comprehensively review the terms of the modus vivendi. The “living, breathing” Global Health Governance constitution would complement the existing governance arrangements and offer a structure for current and future action in the field of public health.

The attainment by all peoples of the highest possible level of health represents a truly noble aim, and it is to this objective that the World Health Organization (WHO) devotes its energy, time and resources. Eradicating disease, advising on health effects, providing life-saving medicines, facilitating access to life-sustaining services, caring for the sick and wounded, creating an environment where people can live good, vibrant, and productive lives—these are the things that bring out the best in humanity. With them, we are able to live *larger* and do *more*.

As the indispensable actor in the field of public health, the WHO contributes to the attainment of this objective in myriad ways. Its universal membership makes it the preeminent venue for intergovernmental relations on issues of health. Its response teams deploy to contain outbreaks of infectious disease and attend to the victims of disaster. Its disease-specific programs take action to eradicate life-threatening illnesses such as HIV/AIDS, tuberculosis, and malaria. Its advocacy and education programs confront chronic disease at all stages of development. Its uniform prescription drug rules ensure consistent access to pharmaceuticals by assigning a single, international name to each chemical compound. Its food safety and medical quality standards protect individuals from ingesting harmful or noxious substances. Its pollution-monitoring mechanisms keep tabs on the natural environment and provide information on corresponding health impacts. Under its Constitution, the organization is charged with no less than twenty-two, clearly articulated functions¹ falling into two broad categories—the direction and coordination of international health work, and technical cooperation with member-states on issues of mutual interest. In this role the organization works tirelessly to deliver health to all humankind.²

Despite these praiseworthy aims and ambitions, the complexities of today’s institutional health environment pose unique challenges to the WHO’s operations. When the organization was formed in 1948, the political structures supporting the institutions of public health could rightly be called *international*. Nation-states served

as the primary units for policy implementation, and national health ministries coordinated with the leaders of the WHO on public health initiatives. Interactions were “relatively simple, with a small cast of actors and [clear] lines of responsibility,”³ and the WHO was well designed to carry out its missions and mandates. The organization’s success in helping to rid the world of polio, smallpox, and onchocerciasis, for example, serve as testimonials to the symbiotic fit between its internal organization and its external operational setting.

Since the end of the Cold War and the emergence of the HIV/AIDS pandemic, however, the structures of public health have changed. The issue has transformed from one of *international* to *global* concern. Nation-states no longer represent the sole, or even the preeminent actors. Alongside national health ministries and international organizations, a number of new entities now exert considerable influence. These include non-governmental and civil society organizations (NGOs and CSOs), such as *Medecins Sans Frontieres*, Partners in Health and Save the Children; public-private partnerships (PPPs) and global funds, such as the U.S. President’s Emergency Plan for HIV/AIDS Relief (PEPFAR), the Global Fund to fight AIDS, Tuberculosis, and Malaria, and the International Finance Facility for Immunization; corporations, including large, multinational pharmaceutical companies like GlaxoSmithKline, Merck, and Pfizer, food manufacturers, including Kraft, Nestlé, and Arthur Daniels Midland, tobacco companies, such as Philip Morris, and firms from the extraction and synthetic industries, such as ExxonMobil, DuPont and Sumitomo; philanthropic foundations, such as the Bill and Melinda Gates Foundation, the William J. Clinton Global Initiative, and the Bloomberg Philanthropies.

Despite the proliferation of actors and initiatives, current programs are failing to solve many of the world’s global health problems. For instance, numerous global health initiatives have either missed or are missing their targets, including the WHO’s “3 by 5” HIV/AIDS initiative and the United Nations (UN) Millennium Development Goals (MDGs). To live up to its lofty aspirations in this crowded, complex, and decentered global health environment, the WHO has had to recognize the necessity of adjusting its *modus operandi*. Recent reform proposals have focused, for instance, on the WHO’s role in global health governance (GHG), and in particular on formulating new strategies for facilitating engagement and coherence between and among the various actors. If the WHO is to continue as the vanguard of global public health, it must figure out ways to incentivize the various global public health actors to participate in a cohesive and comprehensive governance system. The WHO can and should orchestrate a process that enables the many different actors to effectively contribute to the health of all peoples, but this will take continuous effort and well thought-out strategies.

In addressing these new demands and challenges, the WHO faces the imperative of reforming how it operates and how it is structured. Many changes are needed and the process must begin immediately. But in recreating itself, the organization should also remain faithful to its core values and objectives. The politicians, diplomats, medical professionals, development experts, business leaders and other members of civil society who came together to create the WHO did so on the belief that they were constructing a new landmark in international cooperation for public health. As Walter Sharp, who served as a staff official to the International Health Conference of 1946, where the WHO was founded, and as an Administrative Consultant to the Interim Commission of the WHO, wrote of the WHO Constitution in 1947:

The new *Magna Carta* of health, if it receives sustained and generous support from the major countries of the world, and if it succeeds in escaping the curse of bureaucratic timidity, should afford a powerful impetus for progress in man's unceasing struggle against disease, stunted growth, and social maladjustment.⁴

The WHO must recall Sharp's decades old challenge. By acting forcefully in the face of uncertainty and by pushing aside the bureaucratic malaise, the WHO can breathe new life into its operations and reassert itself as the world's leader in global public health.

GLOBAL HEALTH GOVERNANCE

At present the global public health system is defined by a plethora of new actors and processes, greater political recognition, an influx of funding, and an ever broadening set of health challenges. Moreover, the clear lines of responsibility from the era of international public health no longer exist. The new complex, globalized system creates a need for new forms of organization, new rules, new norms, and new expectations. In short, the global public health system needs GHG. The challenge for the WHO has been how, and in what ways, it could take a leadership role in creating system-wide coherence.

A lack of a clear structure is a conspicuous feature of the global health system. The roles played by nation-states, UN organizations, international organizations, NGOs, CSOs, PPPs, and the various funds for instance, are not neatly delineated. Each serves multiple functions: as sources of funding, as originators of initiatives, and as implementers, monitors, and evaluators. Competition among actors and priorities creates additional problems.⁵ Funding and initiatives often totally bypass the governments, introducing complications into the national planning and regulatory processes.⁶ Some have described the system as "open source anarchy" given the wide array of actors and processes that contribute to the formation of global health policies and agendas.⁷

These dynamics pose particular grand challenges to GHG and the functions of the WHO. These include: the lack of global health leadership; the need to harness creativity, energy and resources for global health; the need for collaboration and coordination of multiple players; the neglect of basic survival needs and health systems strengthening; the lack of funding and priority setting; and the need for accountability, transparency, monitoring and enforcement.⁸ It should be noted that each of these challenges is interconnected, and must be viewed within the larger background structure of the global health system as a whole. Therefore, a systemic, multidimensional approach is necessary to adequately and appropriately address each issue.⁹

The WHO leadership and the organization's member-states have been cognizant of the shifting dynamics of the global health system, as well as the operational imperative demanding an active role for the organization in GHG. At the sixty-fourth meeting of the World Health Assembly (WHA), a number of reforms were proposed on the issue of GHG. Specifically, the Director-General identified the objective of "greater coherence in global health," with the WHO serving as the central actor in a process to enable "the many different actors to play an active and effective role in contributing to the health of all peoples."¹⁰

In a follow-up to the Assembly report, the Director-General submitted a report to the Executive Board titled “*WHO Reforms for a Healthy Future*”¹¹ in which she further detailed her reform agenda. On the issue of GHG and the WHO’s role, she asserted that “the key challenge [is] to determine how WHO can engage with wider range of players without undermining its intergovernmental nature or opening itself to influence by those with vested interests.”¹² To respond to this challenge, she suggested that any reform proposals be considered in light of the following principles:¹³

Retention of the intergovernmental nature of WHO’s decision-making;

The development of norms, standards, policies and strategies, which lies at the heart of WHO’s work, must continue to be based on the systematic use of evidence and protected from influence by any form of vested interest;

Neither increasing engagement nor promoting coherence are ends in themselves: any new initiative must have clear benefits and add value in terms of enriching policy or increasing national capacity;

Building on existing mechanisms should take precedence over creating new forums, meetings or structures, with a clear analysis provided of how any additional costs can lead to better outcomes.

In light of these principles, the Director-General made the following proposals to enlarge the WHO’s role with respect to GHG:¹⁴

Widen engagement. In particular this would occur through formal *multi-stakeholder forums* on key issues in global health that would bring together civil society, governments, and the private sector; *separate consultations with different groups of stakeholders*, such as informal working groups made up of stakeholders and WHO representatives that would address specific issues under consideration by member-states; or, finally, consultations through *face-to-face meetings or web-based forums*, in which the role of stakeholders would be restricted to commenting on specific aspects of an issue on which they have particular expertise.¹⁵

Strengthen coordination. This would occur in two separate contexts: *strengthening coordination within the UN system* and *strengthening coordination with coalitions and alliances*.¹⁶

Work in partnerships. In particular, to increase the membership for WHO representatives in various formal arrangements.¹⁷

Develop a framework to guide stakeholder action. Such a framework could be based either on agreed targets and indicators, or it could be modeled on a “code” or “charter” that sets out rights and responsibilities.¹⁸

Since the Director-General made her GHG-related proposals in late 2011, the Executive Board has agreed to the principles elucidated in her reports.¹⁹ At the January 2012 meeting of the Board, the Secretariat made two additional proposals for action, which are currently under the consideration of the Board and the WHA:²⁰

To review and update the principles governing WHO's relations with NGOs;²¹

To develop comprehensive policy frameworks to guide interaction with the private, for-profit sector as well as not-for-profit philanthropic organizations.²²

Summarizing the reform project to-date, it is expected that the GHG-related proposals may eventually result in the establishment of regular consultation with a wide range of partners in global health; the creation of multi-stakeholder working groups and interactive engagements, including a possible *World Health Forum*, convened and/or led by WHO to ensure that all voices are heard; the clarification of roles and responsibilities, with the aims of sharpening the division of labor, avoiding fragmentation, eliminating duplication of effort, and contributing to better health outcomes; and development of a charter or framework for GHG.²³

A practical impediment to the WHO's effectiveness in driving the development of GHG has been the organization's general lack of supranational powers. Under its Constitution, the WHO has no enforcement capacity. Rather, its functions are to *direct, assist, report, propose, and coordinate* issues of international public health.²⁴ As a result, it usually depends on the cooperation of the member-states and the exercise of *soft power* to implement its proposals and programs.

In an effort to control the outbreak of dangerous pandemics, which is where issues of GHG are often most salient, and in an attempt to assert a greater role with regard to national health initiatives and the provision of health security, the WHO substantially expanded its formal supranational powers in 2005 through the adoption of new International Health Regulations (IHRs).²⁵ The new IHRs, which went into effect in 2007, were spurred in part by the UN Secretary-General's assertion of the international human right to health in his March 2005 report *In Larger Freedom: Towards Development, Security and Human Rights for All*.²⁶ Building on this momentum, the IHRs engage both state and non-state actors, address numerous public health threats, and draw together objectives found in multiple international legal regimes, including infectious disease control, human rights, trade, environmental protection, and security, and configure them in a way that has "no precedent in international law on public health."²⁷ Of particular note, the 2005 IHRs give the WHO the authority to declare the existence of "public health emergencies of international concern"²⁸ and issue non-binding temporary recommendations to states concerning how they should respond to such emergencies.²⁹ This moved the IHRs from a limited number of infectious diseases to the broader realm of public health emergencies, and vested substantial supranational power in the WHO Director-General.

The power to declare a public health emergency marked a departure from the previous version of the IHRs, which were first adopted by the WHA in 1969. Under the old IHRs, the refusal of a state to provide information or to cooperate with the WHO

essentially blocked the organization from taking effective actions to address the public health threat. The 2005 IHRs eliminate the ability of a state to veto WHO action on public health emergencies of international concern. States are required to notify the WHO of events that may constitute public health emergencies of international concern³⁰ but the power to declare such an emergency rests with the Director-General.³¹ Importantly, the WHO may also make use of information from non-governmental sources in making its determination about whether a public health emergency exists.³² This allows the organization to substantially expand its surveillance effectiveness. Once a determination has been made, the Director-General must issue temporary recommendations to states on the appropriate responses and health measures that must be taken.³³

Despite the increase in its formal supranational power under the new IHRs, the WHO has struggled to implement the regulations effectively. For instance, with regard to WHO's response to the H1N1 ("swine flu") pandemic in 2009, which was widely viewed by critics as overblown, panicked and disproportionate, an independent review committee convened by the Director-General noted that "the influenza pandemic exposed vulnerabilities in global, national and local public-health capacities, limitations of scientific knowledge, difficulties in decision-making under conditions of uncertainty, complexities in international cooperation, and challenges in communication among experts, policy-makers and the public."³⁴ Based on a thorough analysis, the committee also made three summary conclusions about the functioning of the 2005 IHRs:³⁵

- The IHRs helped make the world better prepared to cope with public health emergencies, but the core national and local capacities called for in the IHRs are not yet fully operational and are not now on a path to timely implementation worldwide.
- WHO performed well in many ways during the pandemic, but confronted systemic difficulties and demonstrated some shortcomings, including with regard to the absence of a consistent, measurable and understandable depiction of severity of the pandemic; the failure to form an impartial and effective Emergency Committee (in accordance with Article 48 and Article 49 of the IHRs); and the failure to disseminate accurate technical information and guidance.³⁶ Despite these failings, the review committee found no evidence of malfeasance.
- The world is ill prepared to respond to a severe influenza pandemic or to any similarly global, sustained, and threatening public-health emergency. Beyond implementation of core public-health capacities called for in the IHRs, global preparedness can be advanced through research, reliance on a multi-sectoral approach, strengthened health-care delivery systems, economic development in low and middle-income countries, and improved health status.

Given these conclusions, it is clear that while the 2005 IHRs may represent a significant improvement upon the pre-existing regime, more time and sustained effort is needed to realize the benefits of the WHO's newfound supranational authority.

A LIVING, BREATHING GLOBAL HEALTH GOVERNANCE CONSTITUTION

The WHO must act to bring greater coherence to GHG. Throughout the world, global health professionals recognize that the proliferation of new actors represents a systematic challenge. This imperative is explicit in the Director-General's proposals, which advocate for wider engagement, strengthened coordination, stronger partnerships, and a framework convention on GHG. This latter item is the most important. By creating a meta-institution of governance, the WHO can bring order to the chaotic environment. This will enable it to engage, coordinate and partner with other actors in a cohesive, non-random fashion. However, the organization must not be dogmatic. Such a meta-institution must provide order to the system without sacrificing the positive aspects of pluralism, flexibility, and fragmentation. A rigid form of constitutionalism, for instance, might have both positive and negative consequences. In order to be effective, the new GHG project must be attuned both to the deficiencies and the advantages of the current global health system.

Existing proposals, including those put forth by the Director-General in her reports attempt to strike a balance between coherence and flexibility. For instance, the Director-General has advocated for increased engagement but has sought to retain intergovernmental control over the process. Other "theories of the whole" reject this dichotomy and advocate for a more inclusive, diffuse governance process. *Shared health governance* for instance, envisions an ethical commitment to health on the part of GHG actors. This theory focuses on principles of justice as the rules of the order. Because no global health *government* exists to enforce these shared ethical commitments, the theory requires a "global health constitution." This constitution need not be written, but instead sets out a "meta-level system of regulation (by self and others) through ethical commitments."³⁷ Importantly, such a constitution would neither replace nor compete with the WHO Constitution. Rather, the two would be complementary.³⁸

Another way to reset the health governance environment is through the formulation of *global health law*. While it does not yet exist, this body of rules would "[encompass] the legal norms, processes, and institutions needed to create the conditions for people throughout the world to attain the highest possible level of physical and mental health."³⁹ It seeks to facilitate health-promoting behavior among the key actors that significantly influence the public's health, including international organizations, governments, businesses, foundations, the media, and civil society. In an ideal environment, the mechanisms of global health law would "stimulate investment in research and development, mobilize resources, set priorities, coordinate activities, monitor progress, create incentives, and enforce standards."⁴⁰

Attention should also be paid to the metaphors that are being used to visualize the GHG system. The usual vernacular focuses on "structures" and "mechanisms," which brings to mind the "architecture" of GHG. Perhaps a better way to think about GHG is through a "source code"⁴¹ metaphor, where each actor shapes the governance environment through his or her contributions and inputs, similar to open-source computer software. The resulting "code" would contain the "normative policy reasons why global health is important to protect and promote."⁴² States, intergovernmental organizations, and private actors would then "apply the source code in diverse political,

economic, and epidemiological contexts, producing different global health ‘software programs’ designed to address particular problems.”⁴³

Each of these “theories of the whole” represents an attempt to solve the fundamental problems GHG. Given the nature of the global health system, the revitalized GHG framework must enfranchise both private and public sector actors. Formal inclusivity, however, is not enough. The GHG structure must also be flexible enough to react to changing conditions on the ground. This requires an institution of governance that is dynamic and subject to continuous revision. Finally, the governance arrangement must create incentives for voluntary participation. Non-governmental actors must believe that they are better off cooperating in the GHG system. Operationalizing these three strategic imperatives yields the following novel proposal—call it *The Living, Breathing GHG Constitution*.

Leveraging the WHO’s existing institutional advantages, including its power to convene, its significant reservoirs of technical and scientific expertise, and its normative strength, the *Living, Breathing GHG Constitution* will result from a series of sequential steps.

STEP 1: The WHO convenes a multi-stakeholder *World Health Governance Forum* (Forum) that is “open to all GHG stakeholders” with the goal of deciding on a framework convention applicable to GHG.

STEP 2: The stakeholders “open-source” the framework convention for a set amount of time (e.g. 6 months) filling it in with specifics; these suggestions are submitted to a “board of editors,” which could be a subcommittee of the Forum⁴⁴ or a working group convened by the WHO Secretariat. The important element is that the board of editors is representative and renowned, and that it includes WHO staff members, civil society, and private sector representatives, and intergovernmental officials.

STEP 3: The editors review the open-source contributions and produce a “global health constitution.” While *non-binding*, this instrument serves as the guiding set of meta-rules (the *modus vivendi*) for one calendar year, at which point it is reopened for comments. Mechanisms might also be developed for “special temporary revisions” that are proposed by the editors. Finally, editors might be available to offer selected “opinions” on GHG questions that will be published on a publicly available website.

STEP 4: The process repeats itself every year, with one month (e.g. January) set aside for commentary, revision and the convening of a Forum, followed by the production of a revised global health constitution.

The attributes to this proposal are numerous. At the outset, it avoids many of the problems of prior governance proposals because it does not attempt to formalize relationships between private and public actors. Rather, the goal is *inclusion* of these various actors in a collaborative process, and the *institutionalization* of the relationships that already exist. For instance, WHO officials and Gates Foundation representatives

already collaborate on a variety of projects, but many of these interactions take place on an *ad hoc* basis. By creating an umbrella *modus vivendi* both the WHO and the Gates Foundation will be able to ground their interactions in a normative, pluralistic, and operationally realistic order. Rather than reacting to different dynamics within the global health system, or recreating relationships in response to emergencies, the new GHG constitution will frame the responses to issues ahead of time, offering a preset structure within which the different actors can pursue their projects. In effect this will serve as a supplement to existing institutions, such as the IHRs, which have been slow to respond to exogenous shocks to the system.

The non-binding nature of the project is also one of its strengths. It will only work if actors believe in its merits and possibilities. By sticking to the structure of a *modus vivendi*, as opposed to a formal intergovernmental agreement, the *Living, Breathing GHG Constitution* cuts down on transaction costs and emphasizes effectiveness. Rather than replacing the WHO Constitution, the resulting arrangement will fill the interstices in the existing order.

The proposal will also lead to the centralization and progressive development of GHG expertise. By bringing together individuals whose sole mission is the development of a cohesive GHG system, the editorial board will serve as a nexus for the formation of a new epistemic community of health governance experts. This community will provide advice, interpretations, and information on the vast uncertainties of the GHG system.

Finally, the proposal is eminently flexible. It has within it mechanisms that can be used to constantly update and revise its provisions. The annual Forum, the “special temporary revisions” and the request for “opinions” can all be conscripted to drive the *Living, Breathing GHG Constitution* in whatever direction the global health community wishes it to go. Refreshing Walter Sharp’s challenge from six decades ago, if this new constitutional project receives sustained and generous support from the major global health actors of the world, and if it succeeds in escaping the curse of bureaucratic timidity, then it should afford a powerful new impetus for sustained progress in humankind’s unceasing struggle against disease, stunted growth, and social maladjustment.⁴⁵

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¹ See Constitution of the World Health Organization, art. 2.

² See Constitution of the World Health Organization, *Preamble*.

³ Nora Ng and Jennifer Prah Ruger, *Global Health Governance at a Crossroads*, 3(2) GLOBAL HEALTH GOVERNANCE 1, 2 (Spring 2011).

⁴ See Walter Sharp, *The New World Health Organization*, 41 AM. J. INT'L L. 509, 530 (1947).

⁵ See Ng and Ruger, *supra* note 3, at 2-3.

⁶ *Id.*

⁷ See David Fidler, *Architecture amidst Anarchy: Global Health’s Quest for Governance*, 1(1) GLOBAL HEALTH GOVERNANCE 1, 2 (Spring 2007) [hereinafter *Architecture amidst Anarchy*].

⁸ These challenges are discussed and analyzed in Lawrence Gostin and Emily Mok, *Grand Challenges in Global Health Governance*, 90 BRITISH MEDICAL BULLETIN 7 (2009).

⁹ *Id.* at 9.

¹⁰ World Health Organization, World Health Assembly, Report of the Director-General, *The Future Financing for WHO*, A64/4 (May 5, 2011) [hereinafter *The Future of Financing for the WHO*].

¹¹ World Health Organization, Executive Board, Report of the Director-General, *WHO Reforms for a Healthy Future*, EBSS/2/2 (Oct. 15, 2011) [hereinafter *WHO Reforms for a Healthy Future*].

¹² *Id.* at ¶87.

¹³ *Id.*

¹⁴ *Id.* at ¶¶88-97. These proposals are also succinctly summarized in the Director-General's remarks to the Executive Board on the issue of GHG-inspired reforms. *See* World Health Organization, Executive Board, *Governance: Introductory Remarks by the Director-General*, EBSS/2/INF.DOC./11 (Nov. 2, 2011).

¹⁵ *See WHO Reforms for a Healthy Future*, *supra* note 13, at ¶¶88-91. Such consultations could be open to all or limited to particular stakeholders. These types of engagements are sometimes called the "PIP model" after the WHO Pandemic Influenza Preparedness (PIP) program, which brought together member-states, industry representatives, other key stakeholders and the WHO to implement a global, member-state developed approach to pandemic influenza preparedness and response. The PIP program became operational on May 24, 2011.

¹⁶ *See id.* at ¶¶92-95. With regard to *strengthening coordination within the UN system*, the Director-General suggested that the first priority is to ensure that the issue of health is actively supported and well-represented in the UN General Assembly and other intergovernmental *fora*. In addition, she suggested that the WHO should focus on high-level coordination through the Chief Executives Board for Coordination, the High-Level Committee on Programmes (HLCP), and the High-Level Committee on Management (HLCM). Finally, she advocated for increased support by WHO to UN Country Teams. In the context of *strengthening coordination with coalitions and alliances*, the Director-General recognized the importance of coordinating with the various non-UN health actors, including funds, development banks, foundations, CSO, NGOs and private entities. Her proposals included forging new alliances from existing mechanisms at both the global level, including through the Inter-Agency Standing Committee health cluster and the Fourth High-Level Forum on Aid Effectiveness and at the local level, including through the Health and Harmonization in Africa program and the International Health Partnership.

¹⁷ *See id.* at ¶96. For instance, independent entities might include the WHO as part of their governance bodies. The WHO could then leverage that presence to drive the work of the partner organization in particular directions. Other partnerships that include independent entities might also be hosted by the WHO. The thrust of the proposal is that the WHO can and should play an important role the various partnerships that exist in the global health system. The idea is that the organization's presence in various partnerships, combined with a strategic plan of action, will bring greater coherence to the global health system.

¹⁸ *See id.* at ¶97. In her report, the Director-General suggested that "in the longer term" a framework for guiding the interactions of the different stakeholders could be developed.

¹⁹ *See* World Health Organization, Executive Board, *Special Session on WHO Reform*, EBSS/2/DIV/2 (Nov. 7, 2011) at 2.

²⁰ World Health Organization, Executive Board, *WHO Reform, Governance: Promoting engagement with other stakeholders and involvement with and oversight of partnerships*, Report by the Secretariat, EB/130/5 Add.4 (Dec. 27, 2011) at ¶14.

²¹ The review will consider widening and improving the modalities for the participation of nongovernmental organizations at regional and global governing body meetings; seeking the views of nongovernmental organizations in the development of new health policies and strategies; and updating practices and criteria for accreditation. *Id.* In relation to the last point, the review will consider ways of differentiating between the different types of NGOs that interact with WHO. *See id.*

²² The proposed frameworks should, *inter alia*, tackle the issue of institutional conflicts of interest. *See id.*

²³ World Health Organization, *WHO: Reform for a Healthy Future: An Overview* (July 20, 2011).

²⁴ *See generally* Constitution of the World Health Organization, art. 2.

²⁵ In accordance with Article 22 of the WHO Constitution, IHRs, which are adopted by the WHA, enter into force for member-states after due process has been given of their adoption, unless a member-state enters a reservation. The presumptively binding nature of the IHRs gives the WHA the power to drive

the content of member-states' positive obligations. All 194 current member-states are parties to the 2005 IHRs.

²⁶ United Nations, Report of the Secretary-General, *In Larger Freedom: Towards Development, Security and Human Rights for All*, A/59/2005, (Mar. 21 2005) at ¶64 [hereinafter *In Larger Freedom*].

²⁷ David Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4(2) CHINESE J. INT'L L. 325, 326 (2005). Fidler adds that "[t]he manner in which the new IHR involve a range of actors, apply to diverse health threats and incorporate public health, economic, human rights, environmental and security concerns reveals an approach to global governance that echoes constitutional law perhaps more than international law." *Id.* It should be noted that the process of revising the IHRs began all the way back in 1995, when the WHA adopted a resolution calling for the revision and update of the regulations. See World Health Organization, World Health Assembly, *Revision and Updating of the International Health Regulations*, A48/7 (May 12, 1995). The Severe Acute Respiratory Syndrome (SARS) outbreak in China in 2003 also served as an important impetus for the project. See Gian Luis Burci and Riikka Koskenmäki, *Human Rights Implications of Governance Responses to Public Health Emergencies: The Case of Major Disease Outbreaks*, in ANDREW CLAPHAM, et al. (ed.), *REALIZING THE RIGHT TO HEALTH* (2009) at 346-47.

²⁸ International Health Regulations (2005) at art. 12. The IHRs define "public health emergencies of international concern" as "an extraordinary event which is determined, as provided in [the IHRs]: (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response." *Id.* at art. 1.

²⁹ *Id.* at art 15.

³⁰ *Id.* at art 6.

³¹ *Id.* at art 12.

³² *Id.* at art. 9.

³³ *Id.* at art 15. In determining whether a public health emergency exists, the Director-General must first consult with the state in whose territory the event arises. If the Director-General and the state agree that a public health emergency exists, then the Director-General shall seek the view of the "Emergency Committee" established under Article 48 of the IHRs on temporary measures. If the Director-General and the state do not agree within 48 hours, then the Director-General shall make a determination in consultation with the Emergency Committee in accordance with Article 49 of the IHRs. See *id.* at art. 12, 48 and 49.

³⁴ World Health Organization, World Health Assembly, *Implementation of the International Health Regulations (2005): Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009*, A64/10 (May 5, 2011) at 6.

³⁵ *Id.* at 128.

³⁶ For a full list of the WHO's failures with respect to the H1N1 pandemic see *id.* at 132-33.

³⁷ Jennifer Prah Ruger, *Global Health Governance as Shared Health Governance*, J. EPIDEMIOLOGY AND COMM. HEALTH 5 (Dec. 14, 2011).

³⁸ See *id.* at 5.

³⁹ Lawrence Gostin and Allyn Taylor, *Global Health Law: A Definition and Grand Challenges*, 1 PUB. HEALTH ETHICS 53, 55 (2008).

⁴⁰ *Id.*

⁴¹ See *Architecture amidst Anarchy*, *supra* note 9, at 2.

⁴² *Id.* at 15.

⁴³ *Id.*

⁴⁴ This tracks an interesting proposal for a WHA "Committee C" that would address GHG issues for the WHO. The WHA already has two committees (A and B) that address managerial and operational issues for the WHA. See Ilona Kickbusch, Wolfgang Hein and Gaudenz Silberschmidt, *Addressing Global Health Governance Challenges through a New Mechanism: The Proposal for a Committee C of the World Health Assembly*, J. OF L. MED. AND ETHICS 550 (Fall 2010).

⁴⁵ See Sharp, *supra* note 6, at 530.

Resuscitating a comatose WHO: Can WHO reclaim its role in a crowded global health governance landscape?

Tess van der Rijt and Tikki Pang

WHO has been guilty of complacency and taking its unassailable leadership role in global health for granted. The WHO's governing bodies are currently engaged in a programme of reform in an attempt to resuscitate the lethargic and archaic organisation. This paper highlights both the internal and external issues facing the WHO and the proposed solutions to these problems and their feasibility of success. It concurrently argues that WHO remains vital to global health governance and in giving low-income and middle-income countries a voice in global health, and outlines its unique role and why it should not be cast aside. Given the likelihood that truly radical change is unlikely to happen, the paper proposes some practical, incremental, achievable and realistic strategies that will allow the WHO to regain its leadership role in global health. WHO must shift its functions to regions, further utilise its rule-making powers to create legally binding agreements, diversify its funding sources, and embrace its capacity to become the knowledge broker and coordinator of global health.

INTRODUCTION

The World Health Organisation (WHO) is facing an unprecedented crisis, related to severe budgetary problems and a struggle to identify and maintain its role in a crowded global health governance landscape. Dr. Margaret Chan, Director-General of the WHO, has stated: 'WHO is overextended and unable to respond with speed and agility to today's global health challenges.'¹ This crisis has led to WHO undertaking an internal reform process in an attempt to reclaim its leadership role in global health. The WHO needs to rediscover the 'why' of its own existence to enable it to decide on the best 'how to' strategy for achieving its noble mission.

WHO IS THE WHO? ISSUES FACING THE ORGANISATION

External issues

A crowded global health governance landscape

The WHO was established post World War II amidst the Cold War era in 1948 and was arguably the only player in global health. As outlined in the WHO's Constitution, the organisation's function includes acting 'as the directing and co-ordinating authority on international health work' and promoting 'cooperation among scientific and professional groups which contribute to the advancement of health.'² However the WHO now finds itself attempting to operate in a global dynamic of 'unstructured pluralism'³ for which it was not designed. New organisations overshadow the WHO, including modern global health initiatives (such as the Global Fund to Fight AIDS, Tuberculosis

and Malaria ('The Global Fund') and the GAVI Alliance), bilateral programmes (such as the United States President's Emergency Plan for AIDS relief (PEPFAR)), well-funded philanthropies (such as the Bill and Melinda Gates Foundation) and technical institutions working in areas which were previously the 'monopoly' of the WHO (e.g. the Institute for Health Metrics and Evaluation, (IHME)). These new initiatives are well resourced and therefore operate independently, and do not need to rely on support from organisations such as WHO to set their agenda. For example, the Global Fund provides roughly 20 percent of international public HIV/AIDS programme funding, 65 percent of malaria funding and 65 percent of tuberculosis funding for 22 high burden countries.⁴ Meanwhile, WHO's combined assessed and voluntary budget is at the same level as the operating budget for the Massachusetts General Hospital, just one American hospital.⁵ The WHO is no longer setting the agenda of global health; instead, it is struggling to keep up.⁶ WHO was once the main source of global health data, but now, although controversial, the IHME has produced the landmark Global Burden of Disease Study 2010. It is considered the most comprehensive description of the totality of death and illness in every part of the world, yet WHO did not contribute to it.⁷ In reality, the global health governance landscape has dramatically transformed over the past 64 years, while the WHO has not. It is time that the WHO reforms to ensure its relevance and reclaim its leadership role.

The global financial crisis

While internal financial issues are discussed in more detail below, the ongoing worldwide financial and monetary crisis is another external factor which has contributed to WHO's budgetary woes. Financial constraints within Member States have resulted in reduced WHO contributions, slow payments and a zero nominal growth situation in the organisation's budget.

Internal issues

WHO governance

While a lot has been written about the unstructured pluralism which exists in global health today, what is often not fully known is that crowded governance exists within WHO itself. For example, WHO has a Bill & Melinda Gates Foundation-sponsored Health Metrics Network, working alongside a Department of Health Statistics and Informatics; it has a Partnership for Maternal, Newborn and Child Health, and a Department of Maternal, Newborn, Child and Adolescent Health; it has a Tobacco Free Initiative Department and a Secretariat to the Framework Convention on Tobacco Control; there is a Global Health Workforce Alliance and a Department of Human Resources for Health. It is an open secret that there are tensions between these entities, as partnerships and initiatives hosted by the WHO have independent boards and subsequently tend to have more resources. This also results in confusion and duplication of efforts at the technical country level. Within the WHO it is well known that the Director-General is not particularly fond of these partnerships and desires to see less of them in the future. The internal crowded governance space constitutes an additional and important dimension to be considered in WHO reform.

Secondly, the governance of WHO is controlled entirely by Member States. As such, other vital players in global health, such as initiatives, philanthropies, the pharmaceutical industry and civil society are unable to take part meaningfully in the decision-making or policy setting processes within the organisation.

Funding and finances

While discussing WHO reform with the Executive Board, the WHO Director-General has stated that 'improvements in financing first require greater clarity about the current and future role of WHO'.⁸ It is widely known that WHO is suffering a budget crisis: in 2011 the organisation slashed its annual budget of \$US4.5 billion by nearly a quarter and announced plans to cut 300 jobs at the Geneva headquarters.⁹ Job cuts and reduction in staff have continued during 2012. The WHO is financed through two streams: Member States pledge a specific proportion of total assessed contributions calculated according to each country's wealth and population; the second stream is through voluntary contributions.

The 'proportional levies' given to WHO by its Member States have not been amended in line with the rising cost of WHO operations.¹⁰ Therefore assessed contributions from Member States have usually equalled approximately 20 percent of the WHO budget. There has been concern as to which Member States will continue to fund the organisation; since the recent global recession, many traditional donors, such as the OECD and European States, have had to scale back commitments. Participants at the informal consultation convened by the Director-General in January 2010 stated that convincing their public and parliaments of the need to increase funding to the WHO was 'hard to sell'.¹¹ Therefore many have hoped that the relatively economically stable BRIC countries would step up their commitments.¹² However the emerging economies of Brazil, Russia, India and China remain predominantly recipient countries, evidenced by examining the Global Fund: Brazil has received \$45 million in grants and only contributed \$200,000 to the fund; Russia has received \$354 million and donated \$254 million; India has received \$1.1 billion and only donated \$10 million; while China has received \$2 billion and donated \$16 million.¹³ It is important to note that although China, India and Brazil are strong emerging economies, they are countries with great poverty and inequality and remain relatively poor in per capita terms. Therefore it is unclear if they will take on additional responsibilities and increase WHO funding. However there are certainly encouraging signs that they will. The BRICS Health Ministers' Meeting released a Beijing Declaration in July 2011, in which they declared their commitment to support and undertake inclusive global public health cooperation projects.¹⁴ Over an approximately ten-year period (2002 compared to 2012-13) China's, Brazil's and India's contributions (as a percentage of total budget) has increased from 1.0%, 1.4% and 0.3% in 2002¹⁵ to 3.2%, 1.6% and 0.53% respectively in 2012-13.¹⁶

Due to financial issues within the traditional Member State donors to WHO, the organisation has relied increasingly on voluntary donations. In 2008-2009, 73 percent of WHO's budget was from voluntary contributions and this percentage is rising each year.¹⁷ Further compounding the resource shortage issue is that donors heavily earmark donations for particular causes, which results in skewed global health priorities and a misalignment between financing and the disease burdens of most Member States. In 2008-2009, the WHO's extra budgetary funding was primarily for infectious diseases

(60 percent) and had negligible allocations for non-communicable diseases (3.9 percent) and injuries (3.4 percent). Yet non-communicable diseases account for 62% of all deaths worldwide and injuries account for 17 percent of the global burden of disease.¹⁸ The increasing financial assistance provided by particular private foundations, such as the Gates Foundation, also raises some significant questions regarding the influence that the Foundation exerts over WHO's priority setting. The Director-General has proposed broadening the base for flexible, unearmarked funding by attracting new donors such as foundations, emerging economies and the private sector.¹⁹

A further WHO funding issue emerges from the fact that the WHO does not practice currency hedging. Revenue to the WHO is received in US dollars, while operations are paid in Swiss francs. Between 2000 and 2010 there was a 34 percent erosion in the weighted purchasing power of the US dollar for the Organisation's payroll costs.²⁰ It is positive to see that the WHO is revisiting fundamental financing issues, which would include the currency of assessment, as part of its reform process.²¹

Decentralised structure

The WHO consists of headquarters in Geneva, Switzerland and six regional offices scattered worldwide. The WHO Constitution states that the regional offices are to adopt their own rules of procedure and the relevant regional committees should appoint their Regional Director.²² The Constitution states that the function of the regional committee is to formulate policies, call technical conferences, cooperate with respective regional committees of the United Nations and tender advice to the WHO Director-General.²³ However the regional offices have independently expanded their functions; there is no longer a top-down leadership structure whereby the regional offices support and provide advice to the Geneva headquarters. Instead the Organisation operates more akin to a federation or partnership. The World Health Assembly and Executive Board formally approve decisions but in practice do not provide tight policy and budgetary control over the regions.²⁴

The Regional Directors exert so much independent authority without consultation with the headquarters, that their messages can conflict and compete with the headquarters and complicate policy coordination and priority setting. For example, the South East Asian Regional Office (SEARO) issued avian flu treatment guidelines in 2007-8 that were inconsistent with those issued by WHO headquarters. Furthermore, the Pan American Health Organisation (PAHO) announced a global health technology initiative with the United Nations Development Programme (UNDP), a broad mission that arguably ought to have originated in Geneva.²⁵ The Regional Directors are also politically elected independently of the Director-General's election and consequently they do not work as a collective political entity. The Director General has no direct influence and/or say on the election of the Regional Directors. In 2010 three of the six regional offices informed the Director-General they would not be supporting her re-election in 2012 and as such the Director-General was required to campaign within these regions.²⁶ To operate effectively, the WHO must be one entity espousing the same mission and priorities.

Difficulties in hiring key experts

The UN personnel system uses a quota system to ensure language and geographic balance. While diversity of employees is certainly a strength, the system requirements and procedures can delay the hiring of key experts and thus skew expertise. Within the WHO itself, administrative tasks have become more complicated as the administrative centre of the organisation has been transferred to Kuala Lumpur in Malaysia. Consequently simple administrative tasks like booking flights have become complex – not only is there a time difference between the two offices, but it is difficult to speak to someone face-to-face if required. Sufficient funding to hire experts is also necessary. A grant provided by the Canadian government enabled the WHO to employ a strong cohort of HIV/AIDS technical advisors for the AIDS '3 by 5' campaign. However this grant recently 'dried up' and competent WHO employees are leaving.²⁷ The current staffing structure of the WHO, along with the fact that the organisation is hamstrung by its donors tied funding, makes the hiring of experts and the performance of administrative tasks overly complex.

Lack of accountability

The United Kingdom Department for International Development (UK DFID) published a report last year that analysed and critiqued multilateral aid organisations to help decide to which organisations its Government should allocate funding to ensure maximum value of their aid budget. While the report identified WHO's comparative advantage as its authority to lead and coordinate others, it was ranked overall as 'weak' on organisational strengths. Listed weaknesses included: there is no clear and transparent system to allocate aid; there is little evidence that WHO curtails poorly performed projects; WHO has no formal disclosure policy and does not publish adequate specific programme or project details; and targets for savings on administration costs are not stretching.²⁸ It is important to note, however, that of the 20 UN agencies and programmes analysed, only five were ranked either 'satisfactory' or 'strong' in the 'organisational strengths' section; the rest, including the WHO, were either 'weak' or 'unsatisfactory'. Both GAVI and the Global Fund were rated as 'strong' in both the 'organisational strengths' and 'contribution to UK development objectives' sections. Both GAVI and the Global Fund were also considered to demonstrate strong and inclusive governance systems.

WHY IS THE WHO IMPORTANT?

As there are so many internal and external issues facing the WHO, why is it not simply dissolved and its resources and staff directed to the various other global health agencies? If the WHO did not exist, a similar entity would have to be created.²⁹ Due to globalisation, urbanisation and increased international travel and trade, coordinated 'global health' is more relevant than ever. WHO Director-General Dr. Margaret Chan has stated, 'In our mobile, interdependent and interconnected world, threats arising from emerging and epidemic-prone diseases affect all countries. They reinforce our need for shared responsibility and collective action in the face of universal vulnerability...'³⁰

WHO as the coordinating authority to set normative standards

As the majority of health risks are oblivious to State borders and national policies, it is vital that multilateral action is effectively coordinated. As argued by Pang and Garrett: 'Governance and the setting of normative standards cannot be accomplished with a slew of loosely connected health initiatives, non-governmental organisations and bilateral programmes. The only entity with a character, legislative body and a mandate to fill that role is the WHO and it must do so decisively.'³¹

While recognising that the WHO is 'not perfect', the US Institute of Medicine (IOM) stated in 2009 that the WHO was the only health organisation with the capacity to lead the proliferation of new participants in global health through its mandate for setting evidence-based norms on health-related technical and policy matters.³² The IOM committee urges the US government to support WHO as a leader in global health by paying its fair share of the organisation's budget and providing technical expertise to WHO. Concurrently, it advises the US government to request a rigorous external review of the WHO. After analysing various global initiatives, the UK Government also recognises that the WHO is critical to the achievement of the health Millennium Development Goals and UK priorities on reproductive, maternal and newborn health and malaria.³³ The emerging BRICS economies also recognise WHO's relevance: 'In our view, WHO has a major role to play in the promotion of access to medication, technology transfer and capacity building with a view to bring more equity to the health sector worldwide.'³⁴

Not only are the Member States recognising the relevance of WHO, but civil society is also. Oxfam has urged the protection of the core functions of WHO in its reform process, after physicians in Pakistan reported unexpected deaths at a public health facility serving mainly poor patients for free.³⁵ It was revealed that the cause of these deaths was isosorbide capsules that were filled in error with antimalarial pyrimethamine. This was due to a breakdown of goods manufacturing practices in Pakistan where there is no federal drug regulatory authority. Kamal-Yanni and Saunders contend that WHO uniquely has the global remit and constitutional mandate to undertake the task of supporting national drug regulatory authority via policy and norms setting and it should continue to do so.³⁶

WHO is fundamental to the facilitation of dialogue on health priorities among Member States and the setting of normative standards, relevant to both Member States and other health initiatives. In the immediate future, its leadership on universal health coverage, which will be tabled at the UN General Assembly in 2013, will be particularly crucial. It should utilise its convening power, neutrality, technical capacity and political legitimacy to implement its authority to lead and coordinate others.

Capacity to enact legally binding agreements

Through the WHO Constitution, the World Health Assembly has the authority to adopt conventions, agreements and regulations with respect to matters of public health.³⁷ As there are so many global health actors, governance has become disjointed and uncoordinated. WHO-created frameworks on ethical research and practices, priority setting, coordination and burden sharing would be welcomed. These frameworks are negotiated and agreed upon by all 193 WHO Member States and so collective action can generally be ensured. The International Health Regulations (IHR) and the Framework Convention on Tobacco Control (FCTC) are two successful international law treaties

that have already been enacted and effectively implemented. The IHR has resulted in an effective global network of surveillance and response as well as building critical capacities in countries to respond to pandemic threats. The FCTC has made important progress in tobacco control worldwide, including the recent passing of legislation to enforce plain packaging for cigarettes in Australia.

Emphasis is returning to multilateral institutions

In the past decades, governments have worked to avert negotiations in cumbersome multilateral institutions such as the WHO and instead have preferred to utilise the more informal and nimble bilateral programmes and public-private partnerships. However the rise of the Global South is transforming global governance.³⁸ Emerging economies such as the BRICS countries (Brazil, Russia, India, China, South Africa) are more state-centric and sovereignty-guarding in their international relations and the BRICS countries will soon be joined by the MIST countries (Mexico, Indonesia, South Korea, Turkey) as a coalition of significant emerging economies. Subsequently, they are more inclined to utilise formal multilateral institutions that respect the process of government at the national level. Nonetheless it should be noted that bilateral negotiations still occur at the World Health Assembly, with power trades being arranged informally before the formal multilateral decision-making at the Assembly, undeniably undermining the process.

While emphasis is returning to multilateral institutions, there is fear that post-2015 with the end of the Millennium Development Goals (MDGs) and post Rio+20, health is being perceived as receiving less visibility and less priority. The first draft of the Rio+20 document *The Future We Want* disappointingly sidelined the importance of health, although in the final version health was better reflected.³⁹ Therefore the role of the WHO as a global health champion is, arguably, even more important.

WHAT REFORMS HAVE ALREADY BEEN PROPOSED AND ARE THEY ACHIEVABLE?

The WHO Executive Board and World Health Assembly have held various sessions on the topic of WHO reform. If WHO can establish high level Commissions for Macroeconomics and Health; Intellectual Property Rights, Innovation & Public Health; Social Determinants of Health and most recently, the Commission on Information and Accountability for Women's and Children's Health, among others, why could it not convene an independent commission to look into its own *raison d'être*? What about the USA's call for an independent review of the WHO alluded to earlier? Instead of a transparent, objective, knowledge-driven and evidence-informed reform process, what has been put in place is a largely inward-looking, almost incestuous, political process akin to a company's board of directors (i.e. the Member States) doing an audit of their own shop (i.e. the WHO). So far it appears to have progressed with the predictable predilection towards 'business as usual' and 'not rocking the boat'.

The external literature abounds with excellent analysis and novel ideas on WHO reform. This section of the paper explores some of the proposed solutions to effectively reform the WHO and considers their feasibility and likelihood of success.

Calls for a more inclusive governance

The general sentiment around WHO reform is that, of the three components being considered in the reform process, (programs/priorities, governance and management), governance is the more problematic and therefore will be discussed at a later stage. Not only is the WHO 'putting its head in the sand', but the cart is being put before the horse, as, arguably, it is necessary to change governance before any meaningful reforms can be enacted. Despite no lack of interest and commitment by WHO to discuss the issues on the reform agenda, governance, the central issue, is not being sufficiently addressed.

There have been calls for a more inclusive governance structure and mechanism that recognises the non-state actors that have become major stakeholders in global health. In contrast to the WHO, representatives from civil society, the private sector and foundations sit on the boards of the Global Fund and the GAVI Alliance.⁴⁰ Both of these organisations however are not a part of the UN system and therefore they do not have the added layer of political complexity when engaging with non-state actors. UN agencies such as the Joint UN Programme on HIV/AIDS engage civil society through advisory committees. Proposals to achieve this have included a 'global health forum' or a 'Committee C' of the World Health Assembly.⁴¹ Such a Committee would also serve to increase the accountability and transparency of WHO's decision making processes.

However, this is unlikely to happen as has been explicitly stated by a senior WHO official:

"Although the Board asked the secretariat to develop more detailed proposals on how WHO can help bring about greater coherence among all these actors" and "while it is important to hear the views of all players involved in global health", "the Board was clear that the intergovernmental nature of the decision making must remain paramount".⁴²

This is a most telling statement and suggests that such a fundamental and radical change towards more inclusiveness is not going to happen short of a total review of WHO's Constitution and, more broadly, of the post-World War II international order, including the Bretton Woods system, the establishment of the United Nations itself and that of its specialised agencies.

The 65th World Health Assembly requested that the Director-General present a draft policy paper on WHO's engagement with non-governmental organisations (NGOs) to the Executive Board at its 132nd session in January 2013. Interestingly while making this request, the World Health Assembly stressed that the Director-General should be guided by the principle that the intergovernmental nature of WHO's decision-making remains paramount. Consultation for this paper has commenced, which included a consultation with NGOs in October 2012 that proposed a new three-pronged policy, which would foster collaboration, enhance consultation and enable participation in WHO governing bodies through accreditation.⁴³ How this is going to be enacted or what this policy will look like is yet to be revealed.

Interestingly, opposition to a more inclusive governance mechanism has been voiced not just by the WHO Member States but also by other stakeholders (such as civil society organisations) who fear that well-resourced stakeholders, such as industry and large philanthropies will exert undue influence on the organisation. Although a more inclusive governance system has been proposed, it appears that such radical reform is unlikely to occur.

Reform to the weight of Member State votes

Currently the World Health Organisation operates on a 'one-vote, one-State' voting system. It has been argued that WHO reform should include reform to the voting system, whereby votes become weighted according to financial contributions, such as the system in place at the World Bank.⁴⁴ Some developed countries have argued that the one-vote one-state system upsets the balance of power in favour of the south.⁴⁵ However it is very unlikely that such a reform would occur, as WHO's coordinating role as an organisation of the world's nation states, where the opinions of even the poorest and smallest nations are heard, would be undermined. Surely if such a reform were to take place, poorer Member States and emerging economies would no longer play an active role in the WHO, the only body with the capacity to assemble the majority of states worldwide on an equal footing.

Reign in the regional offices

There have been some interesting and plausible proposals put forward to reform the decentralised structure of the WHO. Sridhar and Gostin argue that the WHO headquarters should exercise more oversight and control over regional personnel and decision-making.⁴⁶ Or, if decentralised decision-making remains the norm, the WHO should apply the same yardstick across regions to assess efficiency and effectiveness. Minimally, the agency should fully disclose the funds within each regional office and how regions meet health objectives, with monitoring and benchmarks of success.⁴⁷ Jack Chow has called for the WHO to transition to a system of regional coordinators appointed by Geneva and for the Director-General to have a discretionary fund to implement programs rapidly in response to an emergency.⁴⁸ As a result the Director-General would not have to waste time conducting a fundraising tour, which is what Margaret Chan was forced to do in the first few weeks of the H1N1 outbreak. However, given the largely political nature of the election of Regional Directors and the strong vested interests of the various regions, reform in this area is unlikely to happen any time soon despite the perhaps (false) perception that this is largely an internal, administrative matter and should thus be achievable.

Increase WHO's ability to access scientific expertise

As already mentioned, due to the WHO's hiring of personnel system, the capacity to quickly hire necessary key experts is complicated and lethargic. Jack Chow, former Assistant Director-General of the World Health Organisation on HIV/AIDS, Tuberculosis and Malaria, has recommended that an independent global institute of medicine be established, apart from the WHO and apart from the UN personnel system, which has the freedom to recruit and retain scientific staff (which would be analogous to the American Institute of Medicine and the American Senior Biomedical Research Service).⁴⁹ This proposal is perhaps parallel to the Advisory Committee on Health Research (ACHR), which is the highest-level scientific body that advises the Director-General and has counterparts in each of the WHO regions. Rather than recreate the wheel, perhaps it is conceivable that such an institute, as proposed by Chow, could be

reformed and embodied within the ACHR. Greater independence from the WHO itself would be a necessary initial step in its reform process.

FEASIBLE AND ACHIEVABLE WHO REFORM

Assuming that radical change in governance is not going to occur, how can the WHO make viable and practical reforms to reclaim its future leadership in such a crowded health governance space? Firstly, the WHO must set priorities, redefine its comparative advantage and narrow its focus strategically. The WHO has been trying to conduct both vertical programmes on issues such as AIDS, tuberculosis and malaria while concurrently running horizontal programmes, such as pushing for universal health coverage and improved health systems.⁵⁰ The WHO does not have the budget, capacity or means to run all of these programmes successfully. It should focus on a limited set of priorities and realign its resources to support those priorities. WHO leadership also needs to define its niche and comparative advantage. Many suggestions have been put forward in several recent publications and reports but perhaps WHO can regain its leadership by focusing on three strategies:

Knowledge broker and coordinator

WHO should function primarily as a knowledge broker of quality information and evidence. As argued by Jack Chow, perhaps WHO should return to its original intention of it being a 'health consultancy to developing countries, supplying advice, analyses and best practices, though stopping short of directly implementing health programmes.'⁵¹ The WHO should access, synthesise and disseminate information and evidence; it should build countries' capacity for developing evidence-informed guidelines and policies; it should use the information to define norms and standards (e.g. ICD, health information) and it should regulate quality (e.g. the DOTs, health domain in ICANN). Global health policies are only as good as the evidence and information on which they are based. The WHO should be the place where the best science and scientists can be brought together for public health advancement.⁵² Furthermore, WHO should work at an overarching global level, as opposed to a country level. There are so many health initiatives that are experiencing difficulty in 'managing up' and so coordinating these entities is a unique role that WHO could fulfil.⁵³

Create legally binding international agreements

Through its constitution, the WHO has extraordinary rule-making powers to create legally binding international agreements and frameworks. However, the WHO has only promulgated two major treaties in more than 60 years: the International Health Regulations and the Framework Convention on Tobacco Control. WHO has a unique capacity to convene negotiations, which result in legally binding international agreements, and it should seize this opportunity to take a more active role in regulating the world's health. Furthermore, it should play an effective role in monitoring and evaluating their implementation. With so many actors, global health is currently fragmented and so the WHO could offer leadership by setting clear priorities, facilitating coherence and ensuring fair burden-sharing among states. WHO has the exclusive

authority to exert normative power through innovative treaties or through soft power, including codes of practice and guidelines, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel and the Pandemic Influenza Preparedness Framework. Further WHO agreements and frameworks coordinating the actors in global health could result in a more cohesive, coordinated and effective global health governance framework. Agreements currently being informally discussed include a Global Convention on Research and Development and a Framework Convention on Global Health, although this is less advanced and more complex. Other areas the WHO could regulate include counterfeit medicines, alcoholic beverages, food safety and nutrition.⁵⁴

Shift supportive functions to regions

WHO should strategically shift its supportive functions to regions, while the headquarters should focus on core functions. Jamison, Frenk and Knaul propose that headquarters should focus on core functions (which transcend the sovereignty of any one nation state, such as research and development, surveillance and response to epidemics, international legal instruments) while regions (and countries, together with other agencies on the ground) should focus on supportive functions (such as problems within countries requiring collective action at international level due to weak health systems).⁵⁵ Such a structural change would allow a rational division of labor and responsibilities and minimize duplication and confusion. Regions and countries could focus on providing strong technical and programmatic support to countries in various aspects of health and health service delivery while headquarters would provide the norms and standards and best practices/guidelines which would guide effective implementation of the overall WHO mission.

The three strategies proposed above must, in turn, be founded upon improved governance, better transparency and accountability in decision-making and more sustainable and predictable financing. Ways to achieve such reforms, such as a Committee C of the World Health Assembly and unrestricted funding from more diverse sources, including the private sector, have been alluded to previously.

CONCLUSION

“The WHO cannot do everything and to be of value, must do what it does do to the highest possible standards.”⁵⁶ There is currently a leadership vacuum in the global health governance landscape and the WHO is an organisation with great potential to fulfil the role as the leader and coordinator of global health. Currently however, it is facing so many external and internal issues in a more constrained financial reality that it is at risk of becoming redundant, obsolete and irrelevant. To regain its relevance in the global health governance landscape, WHO must reclaim its role as the coordinating authority and knowledge broker of quality information and evidence. It should use its unique normative power to enact legally binding agreements that regulate global health and ensure its effectiveness and it should shift its supportive functions to regions to ensure the greatest use of available resources. Only then will the WHO be able to salvage its leadership role in global health.

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China's Role in Global Health Diplomacy: Designing Expanded U.S. Partnership for Health System Strengthening in Africa

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China is the world's fastest growing economy.¹ China also presents challenges to the United States as differences in trade policy, human rights, and regional interests become more pronounced.² In addition, China remains remarkably quiet on issues of international development and global health, which makes finding areas of strategic alignment with other nation states and global governance institutions, challenging.³ Employing the perspective of global health diplomacy, collaborations in Africa to strengthen health systems have the potential to both improve relations between the two economic superpowers and amplify the public health impact of investments in African nations. This paper presents four collaborative strategies for consideration by the newly established Office of Global Health Diplomacy in the U.S. Department of State.

INTRODUCTION

China is the world's fastest growing economy, second only in size to the United States, and is projected to overtake the United States in world manufacturing by 2016 (Figure 1).⁹ China's growth and relative size are presenting escalating challenges to U.S. trade policy, human rights, and regional interests.¹⁰ In addition, China remains remarkably quiet on issues of international development and global health, which makes finding areas of common interest and strategic alignment with other nation states and global governance institutions, such as the World Health Organization (WHO) and the United Nations Development Programme (UNDP), challenging.¹¹ However, despite these challenges, collaborative strategies may be further developed in public health system issues between the United States and China, with unique opportunities and advantages that could apply to global health interests of both the United States and China in Africa.

Over the last twenty years China has rapidly progressed to become an economic superpower. More recently, China has developed strategic partnerships with African Union member states and hosts regular forums to strengthen economic cooperation with these nations.¹² This relationship with China presents many African states with attractive opportunities for economic development and foreign investment.¹³ These partnerships also present a pathway to enable African nations to play a greater role in the world economy.¹⁴ While economic development is the stated goal of China-African cooperation, strengthening African health systems and institutions is only occasionally mentioned as an aspect of economic cooperation.¹⁵⁻¹⁷ However, to achieve strong economies, countries of Africa must address their frail and underdeveloped health systems and services.¹⁸

Africa has the worst health indicators of any continent on the globe.¹⁹ Africa accounts for only 13 percent of the world's population, but carries 24 percent of the global disease burden.²⁰ Africa has 19 of the 20 countries with the highest maternal mortality rates, 60% of the world's HIV infections, and 90% of the malaria cases.²¹

These burdens are compounded by the inadequacy of health systems that have suffered from enduring problems of conflict, corruption, weak public sectors, and inadequate financing.²² World Bank reports and other economic analyses have described a strong association between health systems and economic development.²³⁻²⁴ However, efforts to strengthen health systems need thoughtful planning, coordination, and a dedicated and sustained effort from all parties that maintain collaborations or provide assistance in Africa.²⁵⁻²⁷

This paper explores the potential value of U.S. engagement with Chinese-African partnerships by expanding and exploiting existing U.S.-Chinese cooperation in global public health within the diplomatic arena. In particular, collaborative efforts to address health system needs among African nations may be a comparative advantage for such cooperation. For example, China's huge investment in physical health infrastructure can reinforce the large health system investments made by the United States and others for the care and treatment of people living with HIV/AIDS (PLWHA).

This analysis of expanded U.S.-China collaborations in Africa begins with a historical assessment of U.S. health investments in African nations. Next, we review lessons learned from U.S.-China cooperation globally; finally, we describe Chinese bilateral partnerships in Africa and discuss a case study of China's response to the Severe Acute Respiratory Syndrome (SARS) event of 2003 as a turning point in Chinese global health engagement. Based on these analyses, we provide four policy proposals for expanded U.S.-China collaborations in Africa for consideration by the newly established Office of Global Health Diplomacy (S/GHD) in the U.S. Department of State.

GLOBAL HEALTH DIPLOMACY

First, it is important to understand how geopolitical relations among nations now involve critical multi-sectoral actions in health and foreign policy. This may be thought of as 'global health diplomacy'. Global health diplomacy, as characterized by Adams and Novotny in 2007, refers to "tools of diplomats and statecraft [that] can be employed for the dual purposes of improving health and relations among nations."²⁸ Jones later described this concept as a useful perspective for diplomats in the U.S. Department of State,²⁹ and by Fidler who suggested that mapping relations among state and international actors can help identify areas of shared interest and assist in forming plans for collective action in global public health.³⁰

The July 2012 U.S. Department of State (DOS) announcement of the formation of an S/GHD, at the same time announcing the closure of the coordinating office for President Obama's Global Health Initiative (GHI), launched in May 2009, illustrates the importance the U.S. government places on this perspective.³¹ According to the announcement, the new S/GHD will champion the original GHI principles, programs, and interagency coordination activities, but will focus this health activity within the diplomatic sector.³²

While the office has yet to publish a plan of action, it has identified priorities and actions, and its establishment in the DOS under Ambassador Eric Goosby (Global AIDS Coordinator) is unique and notable. Diplomats represent the policy interests of their government to other foreign governments and multi-national organizations and have not traditionally been given a mandate to address public health issues. According to requirements set forth in the 1961 Vienna Convention on Diplomatic Relations, the

cornerstone of modern international relations guiding diplomatic interaction among the 193 member states of the United Nations (UN),³³ the United States regularly publishes a list of accredited foreign diplomats (the 'Diplomatic List').³⁴ A review of the Diplomatic List for Winter 2012 shows that only seven of the more than 180 countries accredited to the United States have diplomats with the word "health" in their title.³⁵ No other country has established an entity similar to the S/GHD which will, according to its founding principles, champion global health in the diplomatic arena.³⁶ The establishment of S/GHD itself presents new opportunities in strategic health cooperation among donor nations.

CHINA AND AFRICA – HOW CAN THE UNITED STATES ADD VALUE?

Why would the U.S. government explore expanded public health collaborations with China in Africa? It is important to note that these two nations already have a shared history of public health collaboration. The United States and China have collaborated for more than two decades on infectious diseases (HIV/AIDS, influenza, and emerging infections), cancer, and other non-communicable diseases.³⁷ These collaborations share common goals for improving the practice of public health as well as strengthening public health institutions in detecting and responding to public health problems in the United States and China. Additionally, improving medical infrastructure and health systems are shared global health objectives and stated priorities of African leaders, and such activities may also facilitate economic development and commerce among these partner nations.³⁸⁻³⁹ Despite common goals, strategic cooperation in health development activities on the continent of Africa between the United States and China remains limited.

From the early 2000s, the United States has focused on single disease approaches in Africa. For example, the United States has supported a series of large global health initiatives on HIV/AIDS; in fact, the President's Emergency Plan for AIDS Relief (PEPFAR) represents the largest amount of funding pledged by any nation to a single disease.⁴⁰⁻⁴¹ However, PEPFAR's single-disease approach also supported the development of public health institutions that can tackle additional public health problems that plague African nations.⁴² This was the objective behind the creation of the GHI in 2009, capitalizing on the infrastructure of PEPFAR to tackle other diseases of public health significance.⁴³ For the United States, the next phase of global health investment also coordinated by the DOS includes strengthening health systems.⁴⁴ Drawing upon lessons learned from U.S.-China collaborations and employing leadership of the S/GHD to explore and map potential collective action with the Chinese government presents an opportunity to amplify the public health impact of development assistance by both nations. It also provides the basis to respond to African leaders' call for stronger coordination among donor nations.⁴⁵

To inform new approaches by S/GHD, it is essential to note lessons learned from the United States government's management of global HIV/AIDS. The Office evolved from traditional technical assistance programs, to which PEPFAR added an accountability of ambassadors and thus accorded priority to fostering dialogue at the highest levels of diplomacy between governments. Understanding this evolution is critical to inform how governments need to employ the tools of diplomacy and statecraft to identify common public health problems and map collective action. An important

characteristic of this evolution is the critical role U. S. Ambassadors now play in allocating and directing public health resources.

As the U.S. President's representative to a foreign country, Ambassadors negotiated PEPFAR expansion and Partnership Frameworks directly with leaders of host governments. While the implementing agencies were still responsible for the funds appropriated for their programs, U.S. Ambassadors were held accountable for the overall success or failure of the PEPFAR country program. Authority to make funding recommendations rested with the Ambassador and PEPFAR performance elements were integrated into U.S. Mission Strategic Plans in each target country. This escalation and expansion of public health management accountability to the diplomatic sector was unprecedented and helped engender stronger foreign policy attention overall to global health in embassies abroad and, to some extent, in the DOS as a whole. For example, both the Global AIDS Coordinator and the deputy head of the Office of Global Health Diplomacy routinely attend the Secretary's weekly staff meeting of all the bureau heads.

How PEPFAR SOLIDIFIED DIPLOMATIC LEADERSHIP OF U.S. GLOBAL HEALTH INITIATIVES

A historical review of this evolution of the U.S. government's program to tackle HIV/AIDS in Africa illustrates how the tools of foreign policy and diplomatic negotiations grew to the current prominence seen in the burgeoning field of global health diplomacy. In 2003, President Bush announced PEPFAR in his State of the Union Address,⁴⁶ pledging U.S.\$15 billion over five years, including U.S.\$10 billion in new funding, with a goal of treating two million HIV-infected people with antiretroviral therapy, preventing seven million new HIV infections, and providing care and support to 10 million HIV-affected individuals including orphans and vulnerable children. These first goals became known as 2-7-10 and became a mantra for results-focused action within each targeted host country as well as for the involved federal agencies.⁴⁷ PEPFAR targeted 15 initial "focus" countries, 11 of which are in Africa.⁴⁸

Within weeks of the announcement of PEPFAR, the U.S. Congress acted quickly to authorize the necessary funding.⁴⁹ Locating PEPFAR in the DOS continued the trend of empowering a single non-technical management authority over implementing agencies. The DOS would not only become the 'honest broker' to organize an 'all-of-government' response to HIV/AIDS outside of the United States, but would hold U.S. Ambassadors accountable for performance of the initiative in each host country. The U.S. Ambassador became the explicit leader of each country program, requiring that the United States Agency for International Development (USAID), CDC, Department of Defense (DOD) and other agencies which had legacy, but sometimes uncoordinated, AIDS programs in country, to align to a single country budget, set of goals and operating plan.⁵⁰

By 2008, the end of the first five years of PEPFAR, the initiative either met or exceeded the 2-7-10 goals,⁵¹ prompting Congress to reauthorize the program at a greatly increased U.S.\$48 billion level.⁵² The emphasis on "focus countries" was increased to involve more countries, and new goals were set across a wider range of interventions. The largest investment remained in Africa, mirroring the spread of HIV/AIDS and the desperate need among nations to control and mitigate the impact on populations most in need.⁵³

PEPFAR TO GHI – EVOLUTION FROM SINGLE DISEASE TO STRENGTHENING HEALTH SYSTEMS

In 2009, President Obama began to expand on PEPFAR success and the single disease approach, announcing the new six-year, U.S. \$63 billion GHI, U.S. \$48 billion of which came directly from PEPFAR, which included the United States' contributions to the Global Fund and the President's Malaria Initiative (PMI).⁵⁴ GHI capitalized on the large single disease platforms PEPFAR created and expanded these to tackle other public health problems such as the health of women, newborns, and children through programs focusing on infectious diseases, nutrition, maternal and child health, as well as clean water and neglected tropical diseases.⁵⁵ GHI transitioned PEPFAR from emergency response to strengthening public health systems and encouraging country ownership.⁵⁶ Of the 32 target GHI countries, 22 were on the continent of Africa, and Africa still dominates U.S. foreign health assistance globally.⁵⁷

While PEPFAR continued to expand prevention, care, and treatment for HIV/AIDS, slowing and reversing progress of the epidemic,⁵⁸ the GHI role did not expand as initially anticipated. Congress appropriated little new funding, and the model that required USAID and CDC to coordinate existing programs and activities through GHI proved difficult to implement. Nearly two years passed before GHI recognized the need for a coordinating Director.⁵⁹ The lack of new funding, lack of incentives to cross agency boundaries, and leadership vacuum eventually led to a closure of the GHI Office in July 2012.⁶⁰ The joint announcement, signed by the directors of the United States Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), and the Office of the Global AIDS Coordinator (OGAC), and GHI, explained that the principles, programs and coordination role supported previously in the GHI office would remain in USAID, CDC, and OGAC. However, the new S/GHD office would move global public health more visibly into the diplomatic arena, building upon the success of PEPFAR and engaging the tools of diplomacy and statecraft at the highest levels of government to raise awareness of issues related to global public health.

CHINA'S PUBLIC HEALTH SYSTEM

To understand where opportunities to capitalize on existing U.S.-China collaborations to work in Africa, it is useful to describe the organization of the Chinese health system as well as how U.S. and Chinese public health agencies work together, sharing nearly two decades of various collaborations in public health. China has a single party political system, governed by the Communist Party of China. While this is in stark contrast to the United States and many other countries that maintain a multiparty system of democracy, this centralized system has unique characteristics that need to inform any foreign collaboration.

China has 34 province-level administrative units, similar to U.S. states, including four municipalities, 22 provinces, five autonomous regions, two special districts, and Taiwan, a province handled by a separate Taiwan Affairs Office within the State Council.⁶¹ One critical characteristic of China's intricate bureaucratic structure is a consistent separation of political authority from implementation functions. The Chinese Ministry of Health (MOH) preserves this same separation within the Chinese public health system.⁶²

The highest level of administrative authority is the Chinese State Council. The State Council supervises the MOH, which consists of approximately 100 technical

leaders who set policy and which serve as the main authority for the national public health system.⁶³ Additionally, the MOH supervises the multiple technical implementing agencies including provincial health bureaus. The provincial health bureaus supervise the prefectures health units. This pattern continues down the administrative chain to counties, townships, and village health centers (Figure 2).⁶⁴

One technical implementing agency overseen by the MOH is the Chinese Centers for Disease Control (China CDC), which has also served successfully as the Principal recipient of over U.S.\$825 million for the Global Fund to Fight Tuberculosis, Malaria, and HIV/AIDS.⁶⁵ With authority and purview over the public health component of the Chinese health system, China CDC is the lead technical implementing agency for disease control and prevention at the national level. China CDC has its own counterpart CDC entities at the provincial, prefecture and county levels (Figure 3). This network of authority, supervision, and implementation, yields a health system of more than 2,200 provincial and county CDCs.⁶⁶

COLLABORATIONS BETWEEN U.S. AND CHINESE PUBLIC HEALTH AGENCIES

Due to these characteristics and differences in governmental structure, U.S. governmental counterparts do not align perfectly with Chinese governmental units. Unless the Chinese implementing institution has the appropriate delegated authority from their supervising institution, that institution or agency may find it difficult to engage with a foreign institution on a global health project. This can create significant barriers to collaboration.⁶⁷

Despite these barriers, bridging the U.S. and Chinese health agencies are multiple Memoranda of Understandings (MOUs) between the Chinese MOH, the China CDC, and the U.S. Department of Health and Human Services (HHS), CDC, and the National Institutes of Health (NIH), dating from 1979. These address HIV/AIDS, influenza, emergency preparedness, health communications, emerging and reemerging infectious diseases, and most recently, chronic and non-communicable diseases and tobacco control.⁶⁸ U.S.-Chinese partnerships in public health illustrate how arrangements in other countries where these nations share similar health development agendas.

CHINA IN AFRICA

China's astounding economic growth over the last 20 years has relied on imported natural resources to fuel its industrial development.⁶⁹ China has expanded its quest for natural resources to sub-Saharan Africa, which is rich in natural resources but poor in the infrastructure needed to exploit them.⁷⁰ China and numerous African nations have signed agreements, which in one way or another link natural resources and development assistance.⁷¹⁻⁷⁴ However, typically, there is no transparent plan published by either Chinese or African governments on how this assistance will be supervised or evaluated.⁷⁵

Recently, China has clarified some aspects of their foreign assistance strategy to the international community.⁷⁶ In China's first ever public white paper on foreign aid, published in April 2011, China reported that 51 of the 54 member states of the African Union are receiving assistance, and since 1964 China has distributed a total of U.S.\$31.3 billion in loans, grants, technical assistance, and engaged in large physical infrastructure

projects there.⁷⁷ In 2009 alone, China distributed 46 percent (approximately U.S.\$1.4 billion) of total Official Development Assistance (ODA) in Africa.⁷⁸ To put this in perspective, during this same period, the top three donors in Africa were the United States, which gave U.S.\$7.2 billion, the World Bank, which loaned U.S.\$4.1 billion, and France, which gave U.S.\$3.4 billion.⁷⁹

Beyond the recent publication of the white paper, China's Foreign Ministry has said little publically about China's development strategy in Africa. However, this is in contrast to China's strategy on public health, which post SARS, is becoming more transparent and has recently demonstrated more collaboration with multi-national organizations and external partners.

CHINA AND SARS

How did SARS change China's global health engagement? The SARS epidemic exposed serious weaknesses with China's lack of transparency related to public health issues.⁸⁰ The first SARS case in China appeared in November 2002.⁸¹ The WHO's Global Outbreak and Alert Response Network (GOARN) received reports of a "flu like outbreak" in China through Internet monitoring.⁸² WHO requested information from the Chinese government regarding the outbreak on December 5 and 11, 2002.⁸³ However, according to CNN news reports and several journal reports, Chinese government officials did not inform WHO of the outbreak until February 2003.⁸⁴⁻⁸⁵ This initial lack of transparency about the epidemic delayed the global community's response to a novel and highly dangerous infectious disease agent.⁸⁶⁻⁸⁷ It brought economic and political pressure on China's government for lack of transparency and limited cooperation. China later apologized for the initial delay during the outbreak of the SARS epidemic, confirming the importance of timely reporting and engagement in the response to emergent global health issues.⁸⁸

China's official report of SARS in February 2003 and apology for delaying international notification demonstrates the newfound Chinese governmental authorities' recognition of the importance of cooperation with WHO and other member states.⁸⁹ International officials largely credit the increase in communication with the international community to the leadership of the then new President Hu Jintao and Prime Minister Wen Jiabao.⁹⁰ SARS also marked an increase in cooperation among Chinese scientists, WHO epidemiologists, and U.S. CDC scientists, although there continue to be criticisms of China's global public health efforts.⁹¹

Discussions held during the SARS outbreak led to the HHS's Health Attaché based at the U.S. Embassy in Beijing and the Chinese MOH's Division of International Cooperation, America's Division, to initiate a joint project on emerging infections.⁹² In October 2005, the Chinese MOH and the U.S. Secretary of HHS met to sign an MOU, the U.S.-China Collaboration of Emerging and Reemerging Infections (EID).⁹³ The EID collaboration has produced dozens of peer-reviewed original research papers and maintains a biennial meeting between the HHS Secretary and the Chinese MOH.⁹⁴

Also as a result of SARS, the Chinese CDC developed a real-time Internet-based disease surveillance system to help increase monitoring and reporting on adverse health events.⁹⁵ This electronic disease reporting tool is linked to nearly every health institution in the country and is used to allocate resources, characterize threats, and monitor

disease patterns. This system is additional evidence of China's increased transparency around public health events of national and international importance.⁹⁶

SARS was a watershed event for the Chinese health system and its governmental authorities.⁹⁷⁻⁹⁹ It jumpstarted the development of China's modern health system by illuminating the critical need to detect and respond to public health threats of international importance in a timely and coordinated manner with the global community.¹⁰⁰ China's rapid growth in public health systems and disease reporting infrastructure post-SARS could provide valuable insights, lessons, and practices for both African and American diplomats.¹⁰¹ Additionally, using the lens of global health diplomacy, examining these lessons and practices can join nations around shared needs of greater health impact and security.¹⁰²⁻¹⁰⁵

STRATEGIES FOR EXPLORING EXPANDED U.S.-CHINA COLLABORATIONS IN AFRICA

Why should the United States explore collaborations with China on the continent of Africa? The United States and China have a tense and polarized relationship on many issues. However, this is not the case on issues of global public health, where there are examples of strong U.S.-China collaboration and increased global engagement by China. Employing the perspective of global health diplomacy, collaborations in Africa to strengthen health systems have the potential to both improve relations between the two economic superpowers and to amplify the public health impact of the investments made by these countries in Africa.

The United States and China seek greater stability and economic participation by African nations in the global economy.¹⁰⁶⁻¹⁰⁷ ENREF 12 However, bilateral exchanges between the United States and China do not include public health collaboration with third party countries. If the S/GHD were able to demonstrate diplomatic value in such collaborations, both sides could benefit their own foreign policy priorities. Given the complexity of the U.S.-China relationship and that public health counterparts on both sides do not routinely invite their foreign ministries to meetings, it is difficult to identify how appropriate negotiations could strengthen global health collaboration. However, the formation of the S/GHD in the U.S. Department of State presents a possibly new approach to facilitate these negotiations among diplomatic officials in both countries.

RECOMMENDATIONS

Recommendation 1: Expansion of the S&ED to include a session on global public health

The U.S.-China Strategic Economic Dialogue (S&ED) is one forum that could be used to incorporate expanded public health cooperation. The S&ED is a meeting hosted in alternating capitals of the United States and China and deals with economic issues of the greatest concern to both nations.¹⁰⁸

Presidents George W. Bush and Hu Jintao jointly created the S&ED in 2006.¹⁰⁹ Nine S&ED meetings have occurred since the first meeting on September 21, 2006. From 2006 to 2009, the S&ED was held twice a year, alternating between Washington, D.C. and Beijing. Since May 2008, S&ED meets annually, most recently in Beijing on May 4, 2012. Despite the changing frequency, S&ED continues to be the primary

platform at which leaders of the two nations discuss issues of greatest economic concern.¹¹⁰

The U.S. Department of State and the Chinese Ministry of Foreign Affairs host the S&ED, and the two economic counterparts, the U.S. Department of Commerce and the Chinese Ministry of Commerce, formulate the agenda.¹¹¹ During the May 2012 S&ED, Secretary Geithner led the U.S. delegation, which included Federal Reserve Chairman Ben Bernanke, Secretary of Commerce John Bryson, U.S. Trade Representative Ron Kirk, and others. The S&ED delegation met with President Hu Jintao, Premier Wen Jiabao, Vice Premier Wang Qishan, Vice President Xi Jinping, Executive Vice Premier Li Keqiang, and other senior Chinese officials.¹¹²

The U.S.-China relationship always contains elements both of cooperation on global problems and strategic competition. Those tensions have been apparent in the Obama years, as the U.S. pushes back on Chinese assertiveness in several areas.¹¹³ However, using the lenses provided by health diplomacy, including a topic where areas of agreement can be more easily mapped, and leveraging existing channels of communication among public health institutions that maintain strong collaborative projects, can positively impact negotiations in other fields. In addition, investments in health have direct impact on a nation's wealth, productivity, as well as life expectancy.¹¹⁴⁻¹¹⁶ Hence, including a health section in the S&ED makes good economic as well as diplomatic sense for both nations and provides a platform for additional cooperation opportunities.

However, this addition will take additional coordination and planning on both sides. The S&ED meetings have not included major discussions around health. One complicating factor is health and development partners from United States and China do not align as clearly as economic counterparts. The Chinese government has four ministries that could potentially address health and development issues: the Ministry of Foreign Affairs, the Ministry of Commerce, the Chinese Ministry of Foreign Trade and Economic Cooperation, and the MOH.¹¹⁷⁻¹¹⁸ However, additional advance communication between the U.S. Department of State and the Chinese Ministry of Foreign Affairs (MOFA), can mobilize appropriate counterparts in advance to identify appropriate global public health topics of mutual interest. The advance work and communication normally done between the Ministries of Commerce could be replicated with health counterparts on both sides to formulate the agenda of a special session on global health. The new S/GHD in the U.S. Department of State would be the natural entity to support this type of advance preparation, planning and cooperation.

In addition, trained and experienced health diplomats are already in place in both the U.S. and China and could assist in facilitating this effort. The U.S. Embassy in Beijing maintains a HHS Health Attaché as well as resident staff from the U.S. CDC, NIH and FDA, who work with counterparts from the Chinese MOH, the Chinese CDC, and other Chinese governmental counterparts. Current U.S.-Chinese collaborations include projects on birth defects, influenza, HIV/AIDS, emerging and reemerging infections, cancer, smoking, and most recently, non-communicable diseases.¹¹⁹

Due to the breadth and relative importance placed on these public health relationships since 2005, the HHS Secretary and the Chinese MOH meet biennially to report collaboration progress, facilitate programmatic review, and establish priorities for the ensuing two years.¹²⁰ In addition, the Directors of the U.S. and Chinese CDCs meet annually in alternating cities of Beijing and Atlanta to review Agency

collaborations and set priorities for the upcoming year. These conduits of communication and collaboration could assist the S/GHD and the Chinese MOFA to frame and map in advance appropriate topics for consideration and discussion during a dedicated global health session during the S&ED.

Another area for exploration would be the identification and categorization of requests for technical assistance received by both the U.S. and Chinese public health agencies. Mapping requests for assistance between the two nations would help guide each nation's response and help improve coordination with African nations around public health issues.¹²¹

Recommendation 2: Initiate a collaboration with the African Society of Laboratory Medicine (ASLM) to strengthen public health laboratory capacity

A fundamental part of any public health system is the ability to accurately detect and characterize diseases as well as perform confirmatory tests to timely manage them.¹²² From a clinical perspective, better care can be rendered with accurate disease confirmation. For public health, disease confirmation helps public health professionals mobilize effective prevention and response efforts, as well as evaluate program effectiveness.¹²³

Although laboratories are necessary components of both clinical and public health systems, when compared with specific single disease programs, funding for laboratory systems is most often neglected when resources for medical and public health programs are limited.¹²⁴ Both the U.S. and Chinese health agencies have supported individual disease control programs as well as hospitals and clinics that need functioning laboratory services and systems.¹²⁵⁻¹²⁷ However, laboratory systems require further investments in quality assurance, compliance, and application to address critical public health problems.

From the start of PEPFAR, U.S. agencies anticipated that every country would need to strengthen laboratory systems and institutions. They thus launched several initiatives aimed at building this capacity.¹²⁸⁻¹³⁰ These initiatives included the WHO-African Regional Office (AFRO) committee resolution 58 that called for the strengthening laboratory systems in Africa; the Maputo declaration that called for countries to develop laboratory strategic plans and policies; the launch of the WHO AFRO stepwise laboratory improvement process towards laboratory accreditation; and the issuance of the Kampala statement by a coalition of donor nations, international organizations, and African nations to establish the ASLM in 2011.¹³¹ ASLM is an independent association authorized by African Ministries of Health and dedicated to strengthening the development of laboratory systems on the continent of Africa.

Why would strengthening laboratory systems in Africa be an appropriate project to link U.S. and Chinese interests? First, there is substantial health security benefit to strengthening laboratory systems.¹³² Had strong laboratory systems been in place in Africa, the global HIV/AIDS pandemic could have been curbed long before it threatened to topple governments. In addition, supporting laboratory systems does render economic benefits, as laboratories create stronger market demands for the medical infrastructure needed to maintain them. As China searches for markets in the developing world, collaborations that provide economic opportunities to support laboratory and medical infrastructures, coupled with Chinese own market incentives, could provide new

opportunities for Chinese-owned business.¹³³ There is also a well-defined blueprint for developing and enhancing public health laboratory capacity among African nations, providing a mechanism to channel donor assistance.

Like the MDGs, the global community and African Ministries of Health have endorsed blueprint to grow African laboratory systems, but currently lack capacity to fully implement these systems. Targets for disease reporting established by the World Health Assembly in the International Health Regulations (IHR) to enhance global security, and the MDGs, established to enhance global health and development, strengthen laboratory systems and need a strong a coordinated community of donor support.¹³⁴⁻¹⁵³ The United States and China share economic, security and public health reasons to strengthen lab systems in African. Further, U.S. professional society programs such as the American Society of Clinical Pathology have already engaged with U.S.-based capacity building programs such as PEPFAR.¹³⁶ ASLM may provide an opportunity to exploit these shared interests.

No partner or international donor has yet pledged to meet the massive physical infrastructure needs that laboratories require. However, China overseas construction capacity is far in excess of what the U.S. government can support under PEPFAR and can greatly enhance efforts to build laboratories in Africa.

In this space, China has announced that as part of its package of international collaboration with African nations, it will assist in building more than 50 medical facilities over the next five years.¹³⁷ ENREF 38 The challenge in building the physical medical infrastructure is that unless there is a clear, defined, strategic plan in place to address the human and system capacity needs, it may not be implemented, maintained, nor be useful to the target population. By partnering with the United States, PEPFAR and the ASLM, Chinese medical infrastructure projects could be vetted in advance and integrated into the African government's own blueprints for national and regional laboratory systems. In doing this, the United States, China and selected African nations could greatly enhance health security, economic cooperation, while achieving greater country ownership of critical public health and clinical infrastructure needs that can also address other health needs within the country.

The United States has already demonstrated leadership in this arena by using PEPFAR resources to facilitate the creation and establishment of ASLM.¹³⁸ The ASLM's purpose is to assist donors and help coordinate assistance to any partners who works in clinical laboratory medicine strengthening in Africa.¹³⁹ By engaging China's strength and experience in building medical infrastructure, the impact of the U.S.-supported public health laboratory systems and networks could also be dramatically enhanced and relations among nations strengthened.

Recommendation 3: Initiate a collaboration with the Training Programs in Epidemiology and Public Health Interventions Network to link Field Epidemiology Training Programs and help single-disease programs strengthen African health systems

One multilateral principle that could help coordinate efforts between the United States and China in Africa is one initiated by the Joint United Nations Programme on HIV/AIDS (UNAIDS). UNAIDS instituted a principle of "three ones" in 2004, which both the United States and China support.¹⁴⁰ The principle of the "three ones" states that

every country should have: (1) one national HIV/AIDS program strategy, (2) one national coordinating body, and (3) one national monitoring and evaluation system.¹⁴¹ Despite the laudable nature of these principles, most African countries continue to struggle with the implementation of the three ones as well as the coordination of multitude of donor organizations involved in the national HIV/AIDS responses.¹⁴² However, China is one of the few countries that has been able to successfully implement the “three ones” principles within the Chinese national health system.¹⁴³

Despite hosting many donor organizations working on HIV/AIDS, China's national program implemented a unified coordinating, planning and monitoring system for all organizations working in the country. The U.S. CDC's Global AIDS Program cooperation with China CDC's National Center for HIV/AIDS Control supported this expanded coordination and provided technical assistance to the process.¹⁴⁴ This joint collaboration could also offer a model of donor coordination toward health systems development in African nations.

In 2012, global HIV/AIDS organizations mobilized more than U.S.\$6.9 billion, greater than half of which came from the United States, and more than 70 percent of which went to African nations.¹⁴⁵ Not only did this level of funding proliferate the number of organizations working in HIV/AIDS in African nations, but this also helped create large country platforms around prevention, care, and treatment of HIV/AIDS.¹⁴⁶ One analysis presented at the recent International AIDS Conference in 2012, posited that the future of PEPFAR will be evaluated against its ability to re-purpose these large platforms to address other critical public health problems and to foster country ownership.¹⁴⁷

One health system strengthening initiative already shared between the United States and China is the Chinese Field Epidemiology Training Program (C-FETP). The C-FETP was a result of many years of collaboration between the U.S. and Chinese CDCs, whose respective directors meet annually to review collaboration progress and establish mutually beneficial goals.¹⁴⁸ The FETPs themselves have existed for 30 years and are in over 32 countries worldwide.¹⁴⁹⁻¹⁵⁰

In 1997, a global network of FETPs joined together to form a common governance structure called the Training Programs in Epidemiology and Public Health Interventions Network, or TEPHINET.¹⁵¹ TEPHINET has active national programs in 53 countries and includes many African nations.¹⁵² FETPs all maintain a standard approach to traditional public health training and have resident trainees and staff with similar skills who share common goals in disease surveillance, investigation, and reporting.¹⁵³⁻¹⁵⁵ FETPs also have an annual meeting which is attended by participants from U.S., Chinese, and African Ministries of Health.¹⁵⁶

While China and the United States have never specifically collaborated on global public health projects in African nations, using the platform of health diplomacy among governments, a collaboration agreement negotiated with the TEPHINET network could provide a framework to facilitate staff exchanges, support study tours, and share best practices and shared models of public health practice. In addition, each FETP is funded by their respective government, contributing greatly to expanding country ownership with limited funding. Exploratory discussions could be held during a special session of the TEPHINET annual meeting, or as part of a dedicated session on global health at the S&ED.

Bringing together the United States and China, which have worked together previously and have experience in strengthening public health institutions, can help amplify the collective impact sought by both superpowers in public health. While there are notable differences between the structure of China and many African nations, there are many similarities in approach. Some of the best practices employed in China could serve as models to help African recipient countries improve donor coordination, even if African nations due to differences in governance are not able to replicate the Chinese experience. Even though China is still a developing nation, with huge health disparities between the rural and urban populations, it has emerged as a global player that could help provide assistance to many African nations. By partnering with the United States, the TEPHINET network can also help provide a government framework to share experiences and best practices among countries, to help strengthen responsive health systems in Africa.

Recommendation 4: Encourage greater contributions to the Global Fund

China's either financial or in-kind contributions to global public health institutions such as the Global Fund or the WHO have been marginal. China has been a recipient of the Global Fund assistance, totally U.S.\$826 million from 2005-2012, and there is substantial evidence that China has used these funds to mobilize successful national repossesses to the TB, malaria and HIV/AIDS epidemics in the country.¹⁵⁷ China has also been a contributor to the Global Fund, pledging U.S.\$4 million in 2011 and U.S.\$5 million in 2012.¹⁵⁸

However, with the recent change in Global Fund leadership and funding structure, more effort among donors will be needed. The Global Fund recently held its fourth replenishment meeting for 2014-2016, seeking donor support for an additional U.S.\$26 billion of assistance (Figure 6).¹⁵⁹ In addition, expanding support to the Global Fund would reinforce the Country Coordinating Mechanisms (CCM) established in the country to manage funding. Using the CCM would ensure that each country retains leadership on the use of donor funding and would help reinforce the health system.

The S/GHD would be a perfect institution to convene or facilitate discussions about expanding contributions to the Global Fund and other multilateral global health institutions within the diplomatic arena.

CONCLUSION

We are at a historical crossroad for global health diplomacy and development. China is expanding its development assistance to Africa, and the United States maintains large HIV/AIDS prevention and treatment platforms throughout Africa. Health institutions from both China and the United States share over 20 years of cooperation in many public health efforts and most recently in health system strengthening.¹⁶⁰ The formation of the new S/GHD in the U.S. Department of State presents a unique opportunity to explore new and innovative areas of collaboration with other nations. By improving the U.S.-Chinese relationship with the tools of health diplomacy, better bilateral relations and global public health impact and security can result.

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Stakeholder Views Regarding a Health Impact Fund (HIF), to Incentivise Pharmaceutical Innovation Relevant to Diseases of Poverty

Coles, D., Ruto, E and Frewer, L.J

The HIF scheme, aims to create an alternative (Patent-2), to the existing Intellectual Property Rights (IPR) regime for rewarding pharmaceutical innovations through monopoly patents. Innovators would choose between the traditional IPR approach and the Patent-2 system to recoup innovation costs. Under Patent-2, reward would be based on the positive impact of the innovation on health globally. A two stage, international, expert stakeholder Delphi survey (N=25) was conducted to identify stakeholder requirements for acceptance and implementation of Patent-2. Broad stakeholder support for the scheme was identified. Some practical issues were identified which require resolution. A larger survey (N=84 international stakeholders) was used to validate these findings. Results broadly corroborated the conclusions of the Delphi survey.

INTRODUCTION

Despite recognition of the need to amend the current system of IPR in order to deliver reasonably priced health care to patients around the world¹, the implementation of concrete alternatives has been hampered by pragmatic difficulties to action any change. However, reform of the existing patent system for pharmaceuticals may be achievable through application of a potential two-tiered patent system, involving the traditional IPR patent model together with an alternative “Patent-2” approach.^{2,3} This alternative approach would enable innovators to opt to register their patented product under the “Patent-2” system which involves renouncing any veto powers over the manufacture of the patented medicine worldwide in exchange for title, during the lifetime of the patent, to a stream of reward payments proportioned to the product’s global health impact, facilitating the medicine being sold at minimum cost so maximising its potential impact on the global burden of disease. Patent-2 holders would be rewarded, from a global, publically-funded Health Impact Fund (HIF) in proportion to the impact of their invention on the global burden of disease (GBD)^{1,4}. However, as this approach may not be acceptable to all stakeholders, the aim of the research reported here was to ascertain potential stakeholder and end-user opinions including their priorities for the outcomes (and associated impact measures) of an HIF scheme, together with identification of potential implementation barriers, and thoughts on how these might be overcome.

THE HIF PROPOSAL

Discussion of the weaknesses of the current system of funding innovation in the pharmaceutical sector is provided by Hollis (2008)⁵. Of particular relevance to the issue of neglected diseases and diseases of poverty is the contention that many innovations which would be socially valuable would provide inadequate profits through a traditional

patent system to make investment in R&D profitable for the patentee. In addition, the existing patent system encourages the patentee to charge a price which would simultaneously make the pharmaceutical unaffordable to those for whom it could be beneficial. Hollis (2008)⁵ further argues that the costs of litigation associated with extension of existing patents further hinder innovation processes as they dis-incentivise investment in further pharmaceutical development and innovation. In contrast, a Health Impact Fund⁶ (HIF) would incentivise the development of new medicines with large measurable health impacts, (for example, an effective treatment significantly reducing diseases of poverty such as Tuberculosis, HIV/AIDS or Malaria). The incentive is independent of the ability of the end user to pay, and facilitates access at low prices. Payments from an HIF (which would be funded by national governments, international bodies, industry and charitable funds) would be contingent on impact, measured, for example, in QALYS (quality-adjusted life years). Criticisms of the HIF have focused on practical issues, particularly relating to designing and implementing methods to assess the comparative cost-effectiveness of novel pharmaceuticals, the risk of pharmaceutical companies exaggerating the health impact of a new drug in order to increase payments, international disparity in funding (where public funding of the rewards for invention coming from taxpayers in developed countries, while most of the benefits could accrue to people in developing countries), and difficulties associated with obtaining political support without broad international cooperation⁷. Stakeholder "buy-in" across all sectors is therefore a prerequisite of effective implementation of an HIF, where "stakeholders" include the pharmaceutical industry, national governments, intergovernmental organizations, representatives of civic society, medical agencies, charities, and funding bodies.

STUDY 1: THE DELPHI SURVEY

Delphi^{8,9,10} is an iterative technique used for the systematic measuring and aiding of forecasting activities and decision making, and has been applied across a variety of disciplines. Delphi is recognised as being an effective procedure when reliable consensus of opinion needs to be obtained from diverse stakeholder groups, and involves sequential collection of two or more rounds of questionnaire data interspersed with controlled and anonymous opinion feedback. Often there is an exploratory round, in which key issues are identified. At the end of the process, the 'group's' position is indicated by the average response to the particular questions, although the extent of agreement/disagreement is also noted. The advantage of Delphi over single round questionnaires is that it allows the provision of anonymous feedback, often but not always in a statistically summarised form, although sometimes as quotes from participants. This allows participants to revise opinions in light of the views of other relevant stakeholders. This may provide the basis of greater consensus across the group, as views and opinions are made transparent¹¹.

Delphi has proven to be a useful method for eliciting international expert opinion within the domain of governance, for example, relating to food policy¹², or development of research policy and agenda setting for future research activities¹³. Given the aims of the HIF research, international stakeholder inclusion in the Delphi study was essential. The inclusion of international expertise demands a methodology that makes it feasible to consult with disparate experts and Delphi methodology is highly appropriate to such

objectives, particularly given the need to include geographically dispersed experts with potentially a broad range of views regarding their priorities for an HIF, and where lack of consensus may arise across the stakeholder group¹⁴.

Methods

Potential experts were identified through collaboration and discussion with project consortium members. Thus personal contacts were utilised, an approach proven to be effective in recruiting potential participants to international Delphi surveys in previous research¹². Experts were identified from the community of relevant international policy actors, end-users and other stakeholders, pharmaceutical industry actors, academia and both public and private funding bodies, utilising both personal contacts and cascade methodology. The aim was to obtain a broad spread of representation across stakeholder groups, particularly individuals who were influential in their field.

In an initial round of consultation, a semi-structured questionnaire was developed¹⁵. An invitation to experts to participate in the survey, an explanation of the Delphi process, and a summary of the HIF scheme was also prepared and circulated by email to the 65 identified experts, stakeholders and end-users during June 2009. Participants were also provided with web links to key documents relating to Patent 2 and the HIF approach¹⁶. The purpose of round 1 was to enable participants to comment on the proposed HIF approach, consider its potential acceptability to different stakeholders, identify potential barriers to successful implementation of the scheme, suggest ways in which the scheme might require modification, consider critical success factors relevant to policy development and valorisation, and suggest possible mechanisms and timescales for implementation. The initial invitation made clear that the Delphi methodology used was an iterative process that would require commitment to at least two rounds of responses. The anticipated outcome and analysis of this first round semi-structured questionnaire was to provide qualitative information relevant to policy implementation and obtain expert stakeholder input to the development of a second quantitative questionnaire. The results of round 1 were analysed to identify whether any consensus views had emerged. Minority consensus was classified as 50-79% agreement with 80% or more agreement being classified as a majority consensus.

The second quantitative questionnaire was circulated by email to those participants who had replied to the first questionnaire. Round 2 focused on ranking the barriers and critical success factors identified in round 1. A statistical summary of first round responses (mean group response) was included in the second round, in order to provide feedback to participants regarding anonymous group responses to individual items. Participants were also informed of those responses for which consensus views had emerged. Views on which consensus was achieved in round 1 were not considered for further discussion in round 2.

Delphi round 1 Materials and Results

All questions were developed following consultation with the Innova-P2 project consortium. A copy of the questionnaire and invitation to participants is provided in Annex 1. The key questions asked in round 1 were as follows:

- Is there broad stakeholder and end-user support for the HIF?
- What are the most important barriers to treating diseases of poverty and neglected diseases?
- Are any refinements to the HIF required to address these barriers (including pragmatic issues related to implementation of the scheme)?
- Are the estimated resources needed and assessment measures used appropriate in terms of implementation?

A combination of qualitative and quantitative questions was applied to solicit expert and stakeholder opinion regarding these issues. The profiles of participants who responded to round 1 questionnaire are provided in Table 1. Of the initial participants invited, (65 in total) 24 responded, resulting in a round 1 response rate of 39%. Of the participants involved in round 1, all but 1 responded to the second round questionnaire. The round 1 Delphi survey was conducted in June 2009.

Table 1: Professional affiliations of experts involved in round 2 of the Delphi Questionnaire

Type of organization	Country of professional affiliation (n).
Pharmaceutical companies and providers	Denmark (1) France (1) United Kingdom (1)
International organizations	International (1)
National government	The Netherlands (1)
Health services	United Kingdom (1)
NGOs	International (1)
Academics	Belgium (1) China (5) Kenya (1) Netherlands (1) United Kingdom (2)
Other Stakeholders and end-users	Denmark (2) Netherlands (2) United Kingdom (2)

Participants with industrial affiliations, and from developing, (as opposed to emerging) economies were slightly under-represented (Table 1). Other key stakeholder and end-user groups (representatives of regulatory and ethical bodies, IPR lawyers, patient groups, for example), did not choose to participate, although such individuals were included in the original database. This lack of participation needs to be considered in interpretation of the results. In contrast, researchers from academic institutions were over-represented. It is possible that relevant opinions from representatives of these groups might be reflected by the international and NGO participants, but this cannot be assumed to be the case. Inspection of self-reported occupational titles indicated that the majority of participants were relatively senior within their organizations. Women were

under-represented (83% of the sample were male) in terms of participants who responded.

Consensus opinions identified in round 1

Agreement of more than 80% was assumed to indicate reasonable consensus across the sample.^{11,12} The results indicated that participants agreed on the following items:

- There was a need to adopt “special measures” regarding the treatment of neglected diseases.
- The HIF would provide a greater incentive for the pharmaceutical industry to develop tools to fight diseases of poverty.
- An HIF scheme would encourage commercial pharmaceutical companies to collaborate with publicly funded research initiatives.
- Pharmaceutical interventions should be eligible for an HIF payment.
- Health system innovations should be eligible for a HIF payment.

Seventy-four percent of participants agreed or agreed slightly, and 17% had no opinion that “in addition to national Governments, other donors, such as private foundations, will be willing to fund an HIF scheme”, again suggesting that reasonable consensus existed across the participants. However, almost 60% of participants were unable to estimate whether the proposed size of the fund (US\$6bn) was an appropriate sum for an HIF scheme. The remaining participants provided a wide range of estimates, and indicated that they were uncertain of the accuracy of these estimates. This suggests that a convincing economic analysis of the financial resources required will be essential if institutional and industrial “buy-in” to the HIF scheme is to occur.

Delphi round 2: Open-ended responses from round 1.

Round 2 questions were developed from the round 1 responses, in particular from the qualitative responses of participants. A copy of the Round 2 questionnaire is provided in Annex 2. The survey ran between December 2009 and January 2010. Two researchers involved in the study separately coded these open-ended responses from round 1, developing a coding scheme grounded in the data available. Following development of the coding scheme, participant responses were subsequently recoded using the scheme. Where disagreement regarding coding of responses occurred, the researchers discussed the appropriate code for a particular response until agreement was reached. The categories identified were then used to develop quantitative responses for inclusion in round 2. These are summarised in table 2, and focused on “Barriers to effectively treating neglected diseases of diseases of poverty”, “Incentives for the private sector to invest in treating or curing neglected diseases”, and “Barriers to successful implementation of an HIF scheme”. Participants were asked to rate the importance of items in each category on a five point scale, (anchored by 1 =“not important at all” to 5= “extremely important”).

Barriers to effectively treating neglected diseases of diseases of poverty

A range of potential barriers were identified in round 1. In round 2, participants were asked to rate the extent to which they perceived each potential barrier to be important or unimportant to the treatment of neglected diseases (table 2).

Table 2: Relative Importance of Potential Barriers to Treatment of Neglected Diseases and HIF

Issue	Mean score (SE) N obtained	Mean score (SE) N obtained
Barriers to effectively treating neglected diseases of diseases of poverty		
<i>Current intellectual property rights systems</i>	3.1 (0.2)	4.3 (0.5) 78
<i>Lack of cohesion between different international funding initiatives</i>	3.3 (0.2)	4.5 (0.1) 79
<i>Poor sanitation</i>	3.5 (0.2)	4.5 (0.1) 79
<i>Lack of diagnostic tools</i>	3.6 (0.2)	4.5 (0.1) 79
<i>Treatments take too long, shorter treatment regimes needed</i>	3.7 (0.4)	4.2 (0.1) 79
<i>Lack of political will (national)</i>	3.9 (0.2)	4.5 (0.1) 79
<i>Lack of treatments</i>	4.0 (0.3)	3.9 (0.1) 79
<i>Local health care infrastructure inadequate</i>	4.0 (0.2)	4.7 (0.1) 79
<i>Lack of priority spending on healthcare in the developing world economies</i>	4.0 (0.3)	4.6 (0.1) 79
<i>Lack of incentives for pharmaceutical companies to develop treatments</i>	4.1 (0.2)	4.5 (0.1) 79
<i>Cost of medicines (individuals cannot afford them)</i>	4.1 (0.2)	4.7 (0.1) 79
<i>National governments input into health care</i>	4.2 (0.2)	4.6 (0.1) 78
<i>Poor access to medicine</i>	4.3 (0.2)	4.7 (0.1) 79
<i>Lack of political will (international)</i>	4.3 (0.3)	4.8 (0.1) 79
Incentives for the private sector to invest in treating or curing neglected diseases		
<i>Facilitating Private Public Partnerships</i>	1.7 (0.2)	4.6 (0.1) 79
<i>Creation of new markets for pharmaceutical products</i>	1.8 (0.2)	4.4 (0.1) 79
<i>Create the potential for the industry to make profits</i>	1.9 (0.4)	4.5 (0.1) 79
<i>Economic compensation from international</i>	1.9 (0.2)	4.3 (0.1) 79

<i>governments and organizations.</i>		
<i>Ensuring respect for intellectual Property Rights</i>	1.9 (0.2)	4.0 (0.1) 79
<i>Encouragement and promotion by international governmental bodies</i>	2.1 (0.1)	4.3 (0.7) 79
<i>Compulsory corporate social responsibility</i>	2.5 (0.4)	3.5 (0.2) 78
<i>Voluntary corporate social responsibility</i>	2.9 (0.3)	3.6 (0.2) 78
<i>International governmental regulation/resources allocation</i>	3.4 (0.5)	4.2 (0.2) 78
Barriers to successful implementation of an HIF scheme **		
<i>Developing country governments will not “buy in” to the scheme</i>	3.2 (0.3)	3.17 (0.2) 77
<i>Lack of cohesion between (inter)national development policies and (inter)national research</i>	3.3 (0.2)	4.3 (0.1) 77
<i>Uncertainty about the potential risks, costs and benefits to industry</i>	3.4 (0.3)	4.2 (0.1) 76
<i>The HIF scheme does not deal with information and education of the healthcare chain (including patients and communities)</i>	3.4 (0.4)	3.4 (0.1) 77
<i>Uncertainty about resources required to operationalise an HIF</i>	3.4 (0.2)	4.4 (0.1) 76
<i>The “patent problem” is not adequately resolved</i>	3.4 (0.5)	3.8 (0.2) 77
<i>Uncertainty about the potential size of financial incentives for industry</i>	3.5 (0.2)	4.2 (0.2) 77
<i>Problems with interactions between donor organizations and industry</i>	3.5 (0.4)	3.9 (0.2) 77
<i>Methods for effectively measuring impact are not available</i>	3.6 (0.3)	3.7 (0.2) 77
<i>Difficulties in raising funding from international organizations</i>	3.8 (0.3)	4.3 (0.1) 77
<i>Difficulties in raising funding from national governments</i>	3.8 (0.3)	4.5 (0.1) 77
<i>The HIF scheme does not deal with diagnosis methods and facilities available locally</i>	3.9 (0.4)	4.3 (0.1) 76
<i>The HIF scheme does not deal with drug distribution systems to remote areas</i>	3.9 (0.4)	4.5 (0.1) 75
<i>Lack of cohesion between (inter)national development policies and (inter)national research agendas</i>	3.9 (0.3)	4.3 (0.1) 77
<i>Developed country governments “buying in” to the scheme</i>	4.3 (0.1)	3.6 (0.1) 77
<i>The HIF scheme does not deal with available healthcare personnel locally</i>	4.3 (0.5)	4.4 (0.1) 76
<i>Industry will not “buy in” to the scheme</i>	4.4 (0.4)	4.1 (0.1) 77
<i>Lack of adequate funding at the start of the scheme</i>	4.4 (0.3)	4.4 (0.1) 77
<i>The HIF scheme does not deal with “end of pipe”</i>	4.9 (0.6)	4.4 (0.1) 75

<i>problems</i>			
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*Participants were asked to indicate the extent to which they agreed or disagreed that each of the items identified in round 1 of the Delphi survey (italic) contributed to the main question indicated in the Bold header on a 5 point scale, anchored by 1=agree totally, 5=disagree totally.

** Note reversed “direction” of scales

All the potential barriers were rated as at least slightly important (table 2). The barriers rated as being most important included *lack of political will* (national and international), *the cost of medicines*, *local infrastructure problems*, and *lack of innovation in the pharmaceutical sector targeting diseases of poverty*. Of these, perceived *lack of cohesion between different national funding initiatives* is worth mentioning, as this relates to the development of more efficient and harmonised strategies utilising existing resources, rather than the allocation of new resources to the problem of neglected diseases.

Incentives for the private sector to invest in treating or curing neglected diseases

Issues identified in round 1 as relevant to incentivising the private sector to invest in treating or curing neglected diseases are summarised in Table 2, *Incentives for the private sector*. In round 2 agreement with the relevance of all of the issues identified in round 1 was, on average, above the mid-point of the rating scale. The highest importance ratings were associated with *international government regulation* (tied to resource allocation), and *corporate social responsibility* (either voluntary or compulsory). Greatest agreement focused on *profitability* (including, for example, *the development of new markets*, *respect for intellectual property rights*, and *industry compensation*). Participants also agreed that the potential to *develop effective public-private partnerships* would incentivise industry to direct pharmaceutical innovation activities to the treatment of neglected diseases.

Barriers to successful implementation of an HIF scheme

In round 1, participants were asked to provide qualitative responses to identify potential barriers to successful implementation of an HIF scheme. The different barriers are summarised in table 2. In round 2 all of the barriers were rated as being important barriers to implementing the scheme. The most important barrier related to “*end-of-pipe*” delivery of pharmaceuticals. “Buy-in” (for example, by stakeholders, including industry, and developing country governments) was also regarded as potentially problematic, as was having sufficient resources allocated at the start-up of the scheme.

Measuring the impact of an HIF scheme

Health impact is the basis for payments from the scheme. At present, QALYS have been identified as the potential metric by which health impact could be measured following health interventions. In round 1 of the Delphi, participants were asked to suggest alternative measures which could be used to metricise health impact. Most participants had problems in identifying appropriate metrics, although the following were

mentioned. “New measurements specific to the context of developing countries”, “Morbidity” (depending on the disease)”, “Percentage of treatable diseases currently untreated”, “Mortality (depending on the disease)”, Relapse (depending on the disease), “Consumer uptake of pharmaceutical products”, “Socio-economic potential (of country) improved or restored”, “QALYS”, “DALYS”, and “Preference-based measures (used in conjunction with QALYS)”. In round 2 of the Delphi, participants were asked to rate the extent to which they agreed or disagreed that each of the measures identified would represent an appropriate metric for assessing health impact. Of all the alternatives, the need to develop new metrics “specific to the needs of developing countries” was rated most positively, although many participants responded that they had no opinion regarding this issue, suggesting considerable uncertainty regarding this issue across the stakeholder group. The ability to effectively metricise health impact is an essential element of the scheme, insomuch as pharmaceutical payments from the scheme are contingent on measurable impact. The (lack of) specialist knowledge required to test and validate appropriate metrics of health impact may also have resulted in participant uncertainties in responding. It is important to investigate whether using multiple measures (including developing country specific measures) and triangulating the results is regarded as the most appropriate approach by stakeholders. This may be particularly relevant if the HIF is to include pharmaceutical delivery in developed, as well as developing countries, as Health Impact Measures may not be equally sensitive in different socio-cultural and health service provision contexts. Despite this, common metrics must be included in an assessment battery to enable comparative analysis between the developed and developing world.

Other issues relevant to the implementation of an HIF scheme

In round 1, participants were asked to identify other issues relevant to the implementation of an HIF scheme, and these were coded as before by two researchers. In round 2 of the Delphi, (table 2), the highest level of agreement was obtained regarding the need to develop an “inclusive governance structure for an HIF scheme,” involving all major stakeholders, the “need to focus on diseases other than Malaria, HIV and tuberculosis,” and the need to “develop local capacity and capability in health care”. Participants also agreed that there was a need to pilot and further refine an HIF scheme before it could be “rolled out”.

In the first round, considerable disagreement was identified regarding the extent to which participants perceived that “current IPR systems acted as a disincentive for developing treatments or cures for diseases of poverty.” The question was again asked in the second round, (participants rating their agreement or disagreement with the statement on five point scales anchored by “agree completely” to “disagree completely”), and participants were asked to explain their answers using open-ended responses. Around 26% indicated agreement and 43% disagreement with the statement, the rest neither agreeing nor disagreeing, or indicating that they had no opinion regarding this issue. The groups did not differ in opinion based on whether they worked in a particular sector with each view being held by stakeholders from different sectors. Inspection of the qualitative responses indicated a wide range of potential reasons for this lack of consensus, varying from the need for IPR to incentivise innovation, through to overestimation of the role of IPR in treatment development.

For example:

“Not patentable’ products do not get developed because the financial incentives do not exist”

Director of policy, health organization, UK.

“I think the influence of IPR is slightly overestimated...it is possible to respect IPR and develop more treatments for neglected diseases”

Academic, the Netherlands

The extent to which protection of IPR acts as a potential barrier to the treatment of neglected diseases has not been resolved by the Delphi study.

An HIF scheme would provide an incentive for commercial companies to develop cures not treatments

In the first round, considerable disagreement was identified regarding the extent to which participants perceived that an HIF scheme would provide an incentive for commercial companies to develop cures rather than treatments. The question was again asked in the second round, (with feedback about first round responses). Around 50% of the participants agreed with the statement in the second round, the remainder neither disagreeing or disagreeing, or expressing no opinion. Disagreement tended to be linked to uncertainties associated with the financial mechanisms underlying the scheme.

“To be a true incentive for research, a mechanism such as HIF should provide clear visibility on possible financial compensations at a very early stage in the design of an R and D project”

Pharmaceutical company, Vice President, France

Participants who agreed that the scheme would act as an incentive tended in contrast, to present arguments associated with increased certainty of reward mechanisms.

“If the health impact is captured well, a medicine that cures AIDS, for example, would be given the same value as 10 or 15 years of chronic AIDS treatment. It would be a lot more convenient for companies to receive a reward for providing one treatment, than to receive exactly the same reward for providing treatment during 15 years”.

Academic researcher, international

“Treatment may be more attractive to commercial companies as they are likely to sell more of a treatment product rather than a cure”

Research funder, Director, UK.

Would an HIF scheme primarily benefit developing, as opposed to developed, countries?

In round 1, considerable disagreement was identified regarding whether the primary beneficiaries of an HIF scheme would be in developing, as opposed to developed, countries. The question was again asked in round 2, with provision of feedback from open ended responses from round 1. In round 2, 77% of participants agreed that the benefits of an HIF scheme would apply primarily to developing countries, and so this was treated as a (marginal) consensus agreement. This change in agreement between the two rounds of Delphi is significant and is attributed to the impact in round two of feedback from round 1, which argued convincingly for the funding of the HIF to be primarily applicable to innovation in developing countries and demonstrates the utility of the Delphi approach in expert consultation.

STUDY 2 – QUANTITATIVE SURVEY

A final quantitative survey was carried out, based on the outcome of the two-round Delphi study. The Delphi study was effective in identifying and refining those issues that need to be tested in order to see if the development and implementation of an HIF is viable including certain changes of focus from the scheme as originally devised such as its applicability to health system innovations and developing countries. The purpose of the quantitative study was to validate the results from the Delphi study in a larger sample of high-level experts across a broader range of countries and organizations, who may not have been in a position to commit the time to participate in the qualitative Delphi rounds.

This final survey was conducted using Survey Monkey™ in January 2011. A total of 697 potential participants were sent a personalized email invitation to participate in the survey. The letter of invitation included a brief explanation of the Health Impact Fund, a link to the online survey and links to other documents which provided more in depth information on the HIF concept, using the same materials as for the Delphi study. The questionnaire itself was identical to the Delphi survey round 2 for the items included. Not all responses are reported here for reasons of brevity, and the focus of the results section will be on quantitative items relating to “barriers to fighting neglected diseases or diseases of poverty”, “incentives for the private sector to invest in treating or curing neglected diseases”, and “barriers to successful implementation of an HIF scheme.” A copy of the invitation letter, accompanying documents and questionnaire are provided in Annex 3.

Results of Study 2

The survey sought to draw on the views of key actors in the area of global health, together with those having high level experience and expertise in the field. Six hundred and ninety-seven prospective participants received personal invitations and of these 84 (12%) responded by completing the questionnaire. While low, this response rate is appropriate to validate the results of the Delphi, and is not unusual for expert surveys of this type¹⁰. A good gender balance was achieved with 44.7% of the participants being female and 55.3% male. 27 Countries and the European Commission were represented and of the 84 participants, 30% were at President, CEO or director level in their organization, 21% at professorial or senior academic level, 20% were Departmental

Heads or Senior Advisors, 9% were at managerial level and 4% at Ministerial or UN Ambassador level. Thus 84% of participants indicated they had a high level of responsibility or expertise in areas highly relevant to the HIF (Table 3).

Table 3: Professional affiliations of participants in quantitative survey by sector

Stakeholder Sector	Number of Respondents
Academic	29
Development Agency	4
Health Insurance	1
International Organization	20
IPR (intellectual property right) Law	1
National Government	4
NGO (Non-governmental organizations)	13
Patient group	2
PDP (product development partnerships)	4
Pharmaceutical Industry	2
Regulatory and Ethics	1
Not identified	3

Academics, international organizations and NGOs were overrepresented relative to other sectors. Sixty-two percent of participants were in the 46-65-age range, reflecting the more senior levels at which most respondents were employed within their organizations.

Survey results

There was a high level of support for the HIF in principle, although there was consistent agreement that there are many important barriers to be overcome. There was also high level of agreement that an HIF should be piloted, suggesting that, although there was strong support for the scheme among stakeholder groups, the details of the scheme need to be tested and further refined.

Table 4: High Levels of Agreement

High Levels of Agreement that:	“Special Measures” should be adopted to tackle neglected diseases	An HIF would facilitate the formation of Public Private Partnerships	An HIF should be piloted	Pharmaceutical inventions should be eligible for HIF payments
Agree %	97	92	90	79
High levels of agreement that:	Health system innovations should be eligible for HIF payments	An HIF would incentivize the industry to develop tools to fight diseases of poverty	An HIF should take distribution systems and whole pipeline delivery into account in impact measurement.	An HIF would incentivize industry to develop cures rather than treatments
Agree %	78	77	75	66

However, there was disagreement or uncertainty on a number of points.

Table 5: Areas of Disagreement

Areas of disagreement	Agree %	Disagree %	No opinion %
An HIF should be available for diseases in developed as well as developing countries	42	46	10
Believe their organization would support an HIF	49	16	35
Would industry “buy in” to the scheme	42	16	42

The participants were asked to rate the extent to which they agreed that the different barriers to fighting neglected diseases or diseases of poverty identified in the Delphi study were important (scales as for the Delphi survey). The results are summarized in Table 2. As for the Delphi study, average agreement for all of the barriers was greater than the midpoint of the scale. This lends credence to the robustness of the Delphi process in identifying important barriers. Amongst the most important were lack of political will to deal with the issue, poor access to medicines, cost of medicines, inadequate local healthcare infrastructure, and lack of national government spending on

healthcare in developing countries. Of relevance to the proposal for an HIF is the finding that lack of treatments (i.e. treatments did not exist) was considered an important barrier. Although it ranked last in importance of 14 barriers in the stakeholder survey, given that all barriers were, on average, rated as being important, it arguably makes little sense to pay too much attention to ranking or prioritizing, and further significance testing was not applied. Levels of agreement with the types of incentives available to industry identified in the Delphi study were also high (Table 2).

Participants also answered questions focused on perceived barriers to implementation of the health impact fund, again indicating the extent to which they agreed or disagreed with barriers identified in the Delphi survey (Table 2). Again there were reasonable levels of agreement between the issues identified by the Delphi process and the levels of agreement in the survey regarding their relevance. The most important barriers to the success of an HIF are perceived as relating either to uncertainty about adequate funding provision for an HIF and the HIF not dealing with 'end of pipe' issues. This was supported by some of the comments provided in the free comments section. For example

"The need to address healthcare systems in developing countries, especially the need to increase healthcare and equity of access to services and social support are essential. The availability of "cheap" drugs cannot be expected to drive healthcare allocations by governments."

President – NGO

"The absence of infrastructure to deliver care far outweighs barriers of cost to appropriate technology for the setting".

CEO - International Organization

Although establishing effective impact measures did not have the highest level of agreement in the quantitative study it emerged as an important concern in the free comment section. For example,

"The greatest challenge will be measuring 'health impact'. For those populations which are the most important target for the HIF, the available systems for measuring health status are the weakest in the world and therefore the problem of measuring a change in that status is enormous. Unless this is explicitly and very adequately addressed, it will be difficult to convince the main constituencies - donors, recipient countries and, most of all, the private sector - of the viability of the scheme."

NGO participant

"I know you have considered the difficulty in measuring health impact. DALYs seem a problematic choice, particularly because of all the subjectivity involved in weighing disability, and the problem with the value of life at different stages. On the other hand, even

accepting it, data is not available for every country, so results would be biased."

Academic participant

In addition, concerns were raised about how incentivization would in practice, relate to health impact assessment.

"Incentives are critically important. It is difficult to get the balance right, in terms of incentive levels and conditions that need to be met to receive incentives."

Manager, International Organization

DISCUSSION

There was participant agreement regarding the need for an HIF fund, and consensus that such an approach would facilitate the treatment of neglected diseases. However, some issues needed to be addressed if the final implementation was to be successful. In particular, participants were uncertain as to whether the size of the fund, and the health impact measure(s) to be used as the basis for payments from the fund, were appropriate. This is not surprising as many people not directly involved in pharmaceutical research will have little idea of the magnitude of research costs. However a realistic size for the fund needs to be further thought through and tested. It is also essential to pilot the utility of existing and other metrics, such as Quality Adjusted Life Years (QALYs) or Health Adjusted Life Years (HALYs) type approaches or country specific metrics, in order that a system of impact measures fit appropriate to the scheme be developed. In addition, participants indicated that various barriers (in particular related to stakeholder "buy-in") needed to be overcome if the fund was to be implemented successfully. Concerns related to the focus of the HIF were also identified. For example, participants indicated that the focus of the HIF should extend beyond the "big three" (HIV, malaria, and tuberculosis). It may therefore be more appropriate for on a particular disease of developing countries (such as schistosomiasis or leprosy) which already has a treatment available in developed countries but which is not readily accessible in the developing world and for which an impact assessment might be readily developed. It may then be more appropriate, following such pilot studies, to roll-out the scheme to one or more of the "big three" diseases, and extend to other areas of health. The results also suggest that innovations in pharmaceutical development alone are unlikely to significantly reduce disease incidence, particularly in developing countries, unless they are linked to "end of pipe" measures such as capacity building and further innovation in local health delivery infrastructures. A question then arises as to whether the latter should also be eligible for reward payments in an HIF. Concerns were also raised as to whether the scheme might potentially divert funding from other related research. While the majority of respondents were of the opinion that an HIF would have a positive effect on the efforts of international organizations through collaboration and coordination, and addressing the issue of affordability and supply of medicines for the developing world, some did express concern that an HIF might be an additional demand on a finite funding "pot" and as a result detract from existing programmes funded by

international and national bodies, and other funders. Further work on a cost-benefit analysis may be needed in this regard.

Several issues have been highlighted that merit further discussion. Delivery of pharmaceuticals to end-users in developing countries, the development of efficacious local health service infrastructures, and the development of “political will” (both local and international) are also important elements in optimising health outcomes. However the focus under the current IPR system is on rewarding research delivering the development of new pharmaceutical treatments rather than research on the development and innovation of existing health related-structures and services. Against this, however, in terms of overall impact on population health in developing countries, it is well-established¹⁷ that in most cases improvements in health care delivery is likely to have a bigger effect than the implementation of a new pharmaceutical product. For example, in many developing countries only a minority of the population have access to modern healthcare treatment. In addition, limitations in the capacity of medical staff available to provide health services may mean that by no means all patients receive either the correct diagnosis or an effective management of their treatment. These factors all affect any attempt at reduction of disease burden and reduce the overall impact of any new pharmaceutical intervention. For example, supposing a pharmaceutical company develops a new product for a disease where the original intervention was effective in 50% of the cases treated while the new product is 90% effective, this will not lead to the disease incidence being reduced by a health impact of 80%. Even assuming there is no shortage of product available, if only 35% of the population have access to medical care and only 65% of those receive a correct diagnosis, and therefore the new product, and if the treatment is only managed effectively for 75% of the patients, then there will only be an improvement in population health (impact) of around 7% over the old product. However if at the same time the pharmaceutical company could also improve capacity for diagnosis and management to say 75% and 85% respectively then the health impact for the same product would increase to around 12% over the old product. Improving population access to health care would have an even more dramatic effect on health impact. Combining development of a new pharmaceutical product with a reduction of exposure to the disease would also increase impact significantly; a good example of this has been the provision of bed-nets alongside malaria treatment or prevention. The results of the Delphi survey confirm this view by suggesting that the development of an effective health impact measure is likely to register optimal improvements in health if both novel pharmaceutical development and local health service, and infrastructures issues are considered. However, including both in the proposed HIF may result in a scheme which is too complex and difficult to implement.

Some limitations of the Delphi study need to be mentioned. The first relates to the representativeness of participants in terms of geographical and institutional affiliation. By no means all countries in the world were represented and participants from developing countries and industry were under-represented. Also, although invited, no IPR lawyers or individuals from regulatory bodies and patient groups chose to participate. While their contribution may have brought some additional perspectives it is unlikely that this would have made a significant difference to the consistency of views expressed on many of the key issues by participating stakeholders across a wide range of interests. It should be made clear that the Delphi study asked for individual comments and people responded as individuals, giving their own opinions as experts but not

necessarily the opinions of their organization and so did not act as national or organizational representatives. The key results of the Delphi study were assessed through the quantitative survey, and no major discrepancies or differences between the Delphi results (which focused on identifying the key issues) and the quantitative survey were found. This suggests that the Delphi process was a good predictor of stakeholder concerns associated with the HIF, and this indeed has been supported in other policy areas (see for example, Frewer et al,2011). Furthermore, while the gender balance for the Delphi study was predominantly male (85%), that of the quantitative survey was much more equitable with almost 45% female participants. However as the outcome of both studies was very similar it suggests as expected, that the gender of experts has little or no effect on their opinion in this area. In addition, the quantitative survey could not be said to be representative of all interested stakeholders, as the number of countries and sectors represented was not inclusive. Despite this, it is arguable that the high level of agreement with the key issues presented, suggests that these factors will be important. Furthermore, although the original experts for the first round of Delphi were recruited in 2009, results from the study continued to be gathered until 2011. Much has been written both for and against the HIF concept and the Delphi study itself may have had some impact on developing opinions by bringing the scheme to the attention of the high level experts who participated in the study. There does appear to be growing support for at least pilot studies of a HIF scheme from entities such as The Global Fund, international organizations such as WHO, and some national political entities, particularly in Germany and Canada^{18,19}.

Given the general level of support for the HIF scheme, it is necessary to translate the results of this study into concrete and actionable policy recommendations. The following are clearly important in this respect.

PILOT STUDIES

Pilot studies are needed to test the validity of all the barriers identified and whether these can be overcome. There also remains lack of clarity as to the impact assessment measures that would be most appropriate. As there is some support for the possibility of country or disease specific impact assessment metrics, more than one pilot study would be needed to assess different measures. As a consequence, a series of pilot studies should be developed and costed.

Practical financial support should be secured from key stakeholders to fund the pilot studies to test the concept. Potential funders could include the European Commission's DG DEV and DG RTD, USAID, The Global Fund, UNDP/WHO, National development aid funders e.g. DFID, BMZ etc., and the pharmaceutical industry. It is suggested that, because of the high level of industrial commitment required to successfully implement the HIF scheme, the involvement of at least two or more pharmaceutical companies at the pilot stage would be essential, would encourage the necessary industry "buy-in" to the scheme, and ensure that its objectives align with industry objectives.

DEVELOPMENT OF A ROAD MAP

Results from the pilot studies could give rise to a Road Map (perhaps in conjunction with the Global Fund and WHO) demonstrating how the HIF would be implemented

and how the potential barriers would be overcome. This road map could be used to demonstrate the potential advantages of the scheme to all interested stakeholders, as well as provide evidence of the practical applicability of the scheme regarding its future operationalization.

CLARIFICATION OF THE CURRENT HIF SCHEME

The current proposal for an HIF scheme does not distinguish between diseases of poverty and chronic diseases of the developed world, nor does it envisage HIF rewards being allocated to health system innovations but focuses instead on pharmaceutical innovation. However, because of the high level of stakeholder support for an HIF to take into account health system and other end-of-pipe issues, it is essential for the HIF to clarify whether it sees its objective primarily to develop a mechanism for encouraging the pharmaceutical industry to develop products for neglected diseases or whether it's primary objective is to reduce the global burden of disease. These two objectives are very different and where the focus of an HIF lies will determine not only the scheme infrastructure, the nature of the pilot studies and the practical operationalization of the scheme but will also impact on the level of support from different stakeholder sectors. Thus it will be essential for any HIF scheme that is to be implemented to be clear on its focus and whether it will make any distinction between rewarding health impacts on diseases of poverty and diseases of the developed world. For diseases of the developing world, the biggest health impacts are likely to result from health system innovation leading to better prevention and better delivery of medicines rather than simply the discovery of new pharmaceutical products. The most significant health impacts will be achieved by health system and pharmaceutical innovations working together. The HIF scheme must therefore be clear on whether and to what extent health system innovations, either alone or in conjunction with pharmaceutical innovation will be eligible for HIF rewards and impact metrics must be developed that are able to take account of this.

CONCLUSIONS

The results of the two studies suggest that there is considerable stakeholder and end-user support for an HIF scheme in principle, although some practical difficulties will require resolution prior to implementation of an HIF. These include the focus of the scheme (in terms of diseases included, size of the scheme, appropriate and effective metricization of health impacts, and whether the HIF should include other health interventions over and above pharmaceutical developments). Potential diversion of funding from other initiatives was also perceived as problematic, and would need to be considered through an effective international harmonization of funding practices. Most people agree that an HIF would incentivise industry to greater involvement in fighting neglected diseases and diseases of poverty, and increase collaboration with the public sector. There is strong support for an HIF to be piloted and this is also regarded as a precondition to full implementation in order to validate and refine operationalization of the HIF scheme. Despite this overall support, there remain serious concerns about potential barriers to successful implementation of an HIF. Therefore practical support

and funding to implement an HIF may not be forthcoming unless policy-makers, funders and industry can be convinced that these barriers can be overcome.

ANNEXES

ANNEX1 - Copy of invitation to participate in Delphi study and Questionnaire for Round 1

ANNEX 2 – Copy of questionnaire for Delphi study Round 2

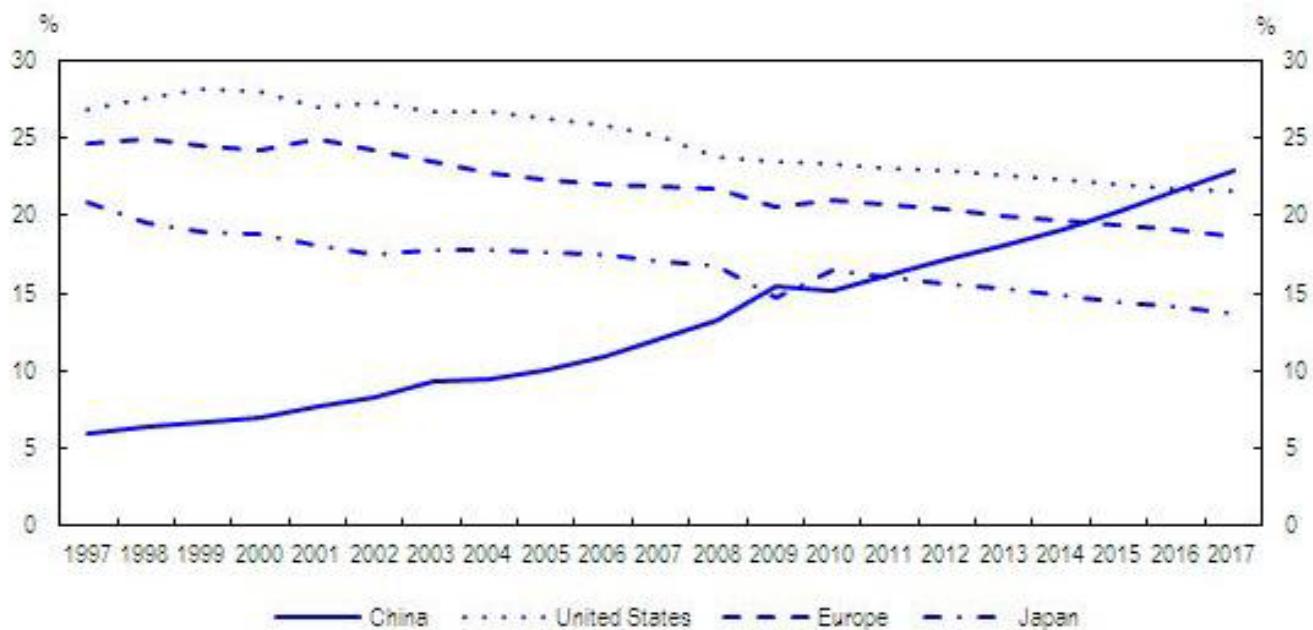
ANNEX 3 – Copy of invitation to participate in Quantitative Survey and copy of Quantitative Survey questionnaire

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Figure 1: Shares in world manufacturing value-added at constant 2000 market prices,
comparison of China, United States, Europe, and Japan



Source: World Development Indicators; OECD estimates for 2009 and later.

FIGURE 2: CHINESE HEALTH SYSTEM FOR DISEASE CONTROL

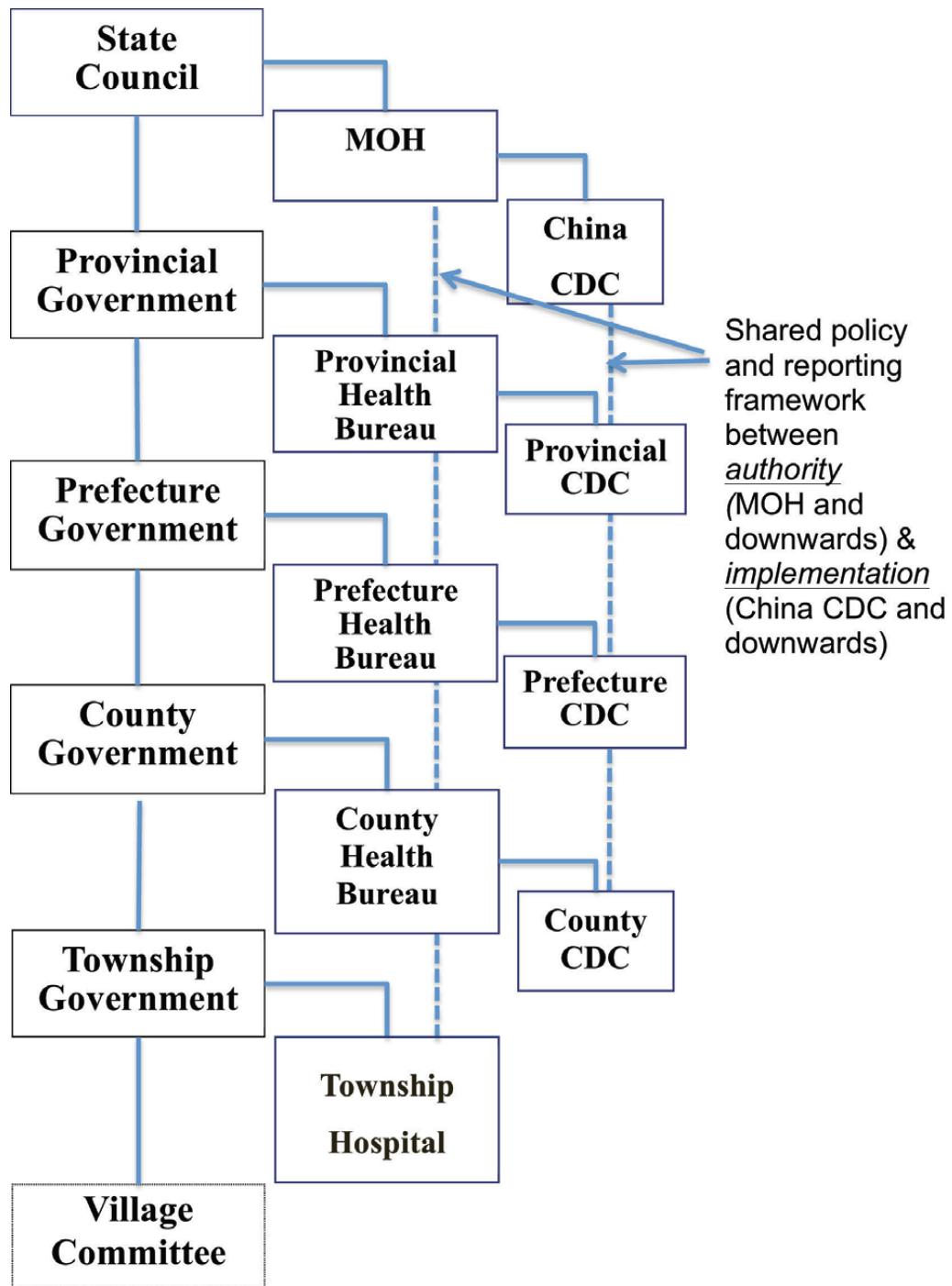


FIGURE 3: CHINESE MEDICAL TEAMS SENT TO AFRICAN NATIONS, YEAR, SENDING CHINESE PROVINCE, RECEIVING AFRICAN COUNTRY (1963-1989)

1963	Hubei Province	Algeria
1964	Jiangsu Province	Zanzibar
1965	Jilin Province	Somalia
1966	Liaoning Province	North Yemen
1967	Tianjin	Congo
1968	Zhejiang Province	Mali
1968	Shandong Province	Tanzania
1968	Heilongjiang Province	Mauritania
1968	Beijing	Guinea
1970	Anhui Province	South Yemen
1971	Shaanxi Province	Sudan
1971	Guangdong Province	Equatorial Guinea
1973	Hunan Province	Sierra Leone
1973	Jiangxi Province	Tunisia
1973	Hebei Province	Democratic Republic of Congo (former Zaire)
1974	Henan Province	Ethiopia
1974	Shanxi Province	Togo
1975	Shanxi Province	Cameroon
1975	Fujian Province	Senegal
1975	Gansu Province	Madagascar
1975	Shanghai	Morocco
1976	Guangxi Province	Niger
1976	Sichuan Province	Mozambique
1976	Sichuan Province	Sao Tome and Principe
1976	Beijing	Burkina Faso
1976	Guizhou Province	Guinea-Bissau
1976	Liaoning Province	Kuwait
1977	Tianjin	plus canopy
1977	Guangdong Province	Gambia
1978	Ningxia autonomous region	Benin
1978	Henan Province	Zambia
1978	Zhejiang Province	Central Africa Republic
1981	Fujian Province	Botswana
1981	Shanxi Province	Djibouti
1982	Inner Mongolia Autonomous Region	Rwanda
1983	Yunnan Province	Uganda
1983	Beijing	Libya
1984	Sichuan Province	Cape Verde
1984	Heilongjiang Province	Liberia
1985	Hunan Province	Zimbabwe
1985	Shandong Province	Seychelles
1986	Qinghai Province	Burundi
1989	Jiangxi Province	Chad

Source: X. Ping, "Chinese medical teams," *Xinhua (Chinese news service)* 2005.

Link: http://news.xinhuanet.com/ziliao/2009-04/13/content_11178783.htm

FIGURE 4: OFFICIAL DEVELOPMENT ASSISTANCE FROM ALL DONORS TO AFRICA IN U.S.\$1960-2011⁴

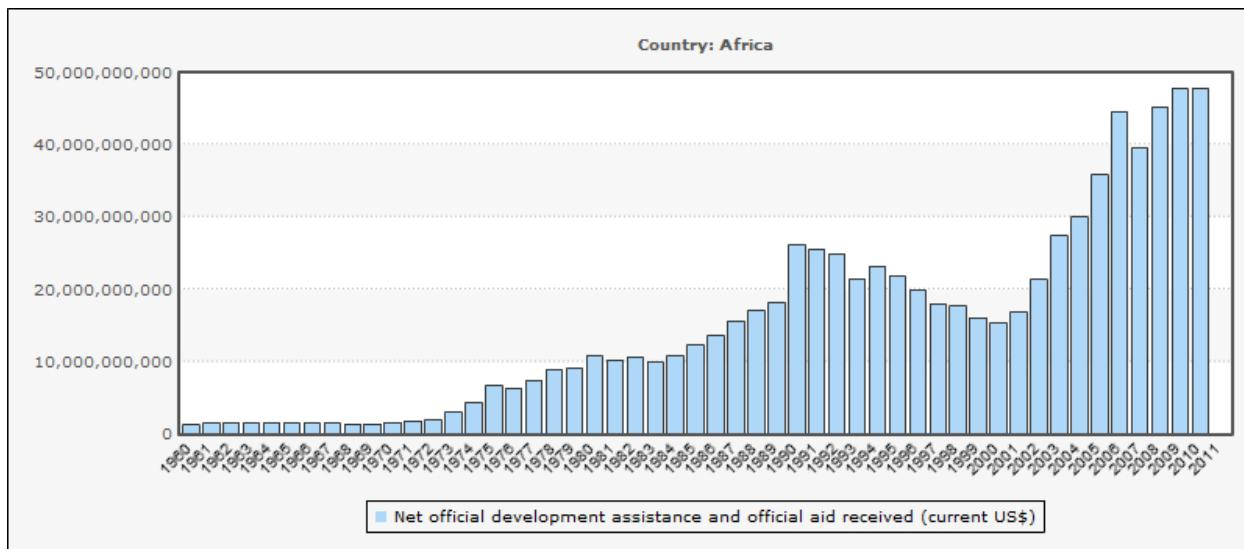


FIGURE 5: OFFICIAL DEVELOPMENT ASSISTANCE TO AFRICA FOR HEALTH FROM ALL DONORS, COMPARED WITH U.S. ASSISTANCE TO AFRICA, 1960-2010⁴

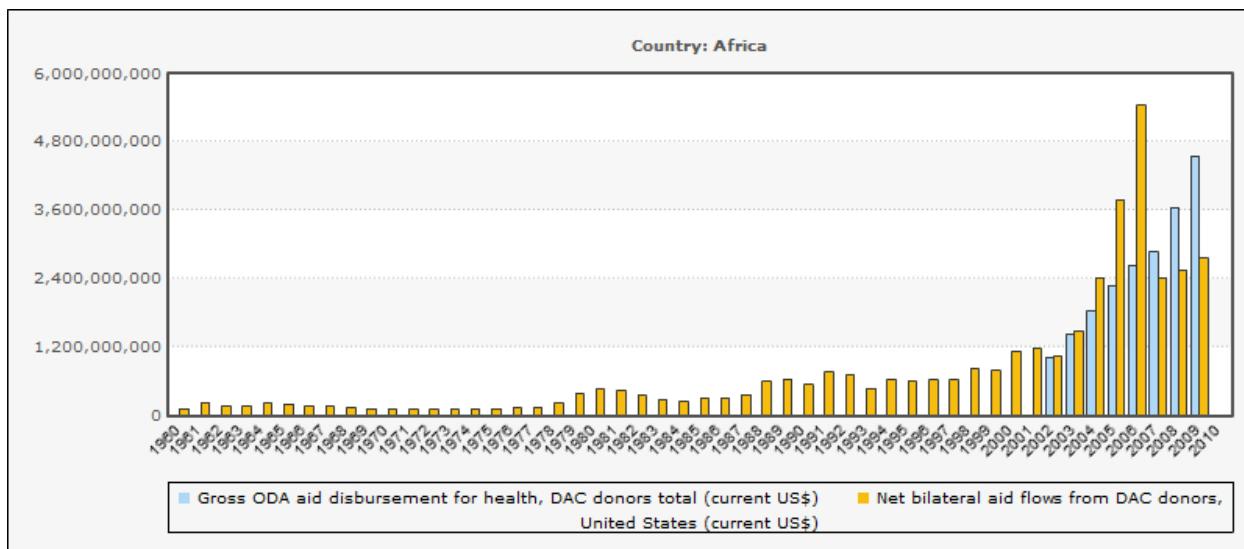
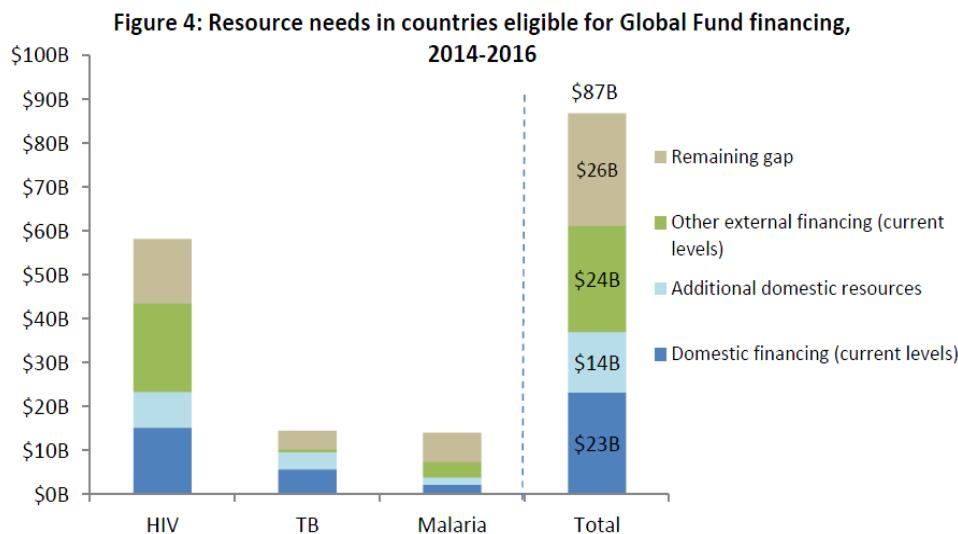


Figure 6: Resource needs in countries eligible for Global Fund financing 2014-2016



Global Fund Fourth Replenishment
Needs Assessment 2014-2016

April 2013

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