Who governs World Health?

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Abstract

After World War II the World Health Organization (WHO) was established with a clear mandate to "act as the directing and co-ordinating authority on international health work".
Since the 80's, in line with the advent of neoliberal policies the holistic approach to health was dismantled, attention became focussed merely on the control of single diseases, the World Bank progressively increased its influence,WHO's regular budget was frozen and the Organization became progressively dependant on "voluntary" contributions from rich countries and other actors, using the economic leverage to impose their own priorities.
With the advent of new powerful actors on the scene, at the beginning of the new century Global health governance became crowded with players with different interests and powers. Factors both internal to the UN and external to the system (corporate sector, G8, Global Public-Private Partnerships, global political and economical environment) have been pushing in the direction of health commercialization affecting its global policy-making.
The paper tries to map the balance among these factors which are obviously interconnected and suggest that in the interest of "health for all" WHO should be allowed to recover its original mandate and authority.

Introduction

"For me health policy is about process and power" wrote Gill Walt in indicating the need to analyse "who influences" whom in policymaking. Walt recognised that in an interdependent world "governments are increasingly affected by international policy procedures" and tried to define who is driving decision-making at that level[1]. The purpose of this paper is go through a synthetic review of historical influences and update the map of Global Health Governance, in order to answer to the question: Which processes and powers have been driving decision-making at global level?[2]

The challenge to the global mandate of WHO

In 1948, the member states of the newly formed United Nations gathered together to create the World Health Organisation; the international community established "The attainment by all peoples of the highest possible level of health" as the objective of the new organisation which received the mandate to "act as the directing and co-ordinating authority on international health work".[3]

By identifying Health as a fundamental human right and defining it as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" it was implicitly recognised that the promotion of good health could not be pursued through medical care alone, nor through the sole the control of diseases, but would require a much wider and inter-sectoral outlook. By recognising that the Health of all peoples as an indispensable condition to the attainment of peace and security of the world, and dependent upon the fullest co-operation between individuals

and between states, as well as indicating "unequal development in different countries in the promotion of health and control of disease" as "a common danger", both the global nature of health-related issues and the connection with international relations was made clear.

Synthetically WHO was established as an intergovernmental agency that exercises international functions with the goal of improving global health; naming the new organisation the World Health Organisation also raised sights to a worldwide "global" perspective[4].

In 1977, under the leadership of Hafdan Mahler, the Dane who served as a Director General from 1973 to 1988, the World Health Assembly adopted the goal of "Health for all by the year 2000" and the following year, with the Alma-Ata Declaration, Primary Health Care (PHC) was identified as the best strategy toward that objective, not only as an integral part of each country's health system, but of it's entire social and economic development, in a view based on equity and community participation, focussing on prevention and appropriate technology, with an integrated inter-sectoral approach to development.

Immediately after the Declaration of Alma Ata, a number of governments and agencies pretended the PHC approach to be idealistic and pushed to reduce the spirit of Alma Ata to a practical set of technical interventions. It is reported that on the following year a conference was held in Bellagio, Italy, sponsored by the Rockefeller Foundation and supported by the World Bank, with in attendance the vice-president of the Ford Foundation, the administrator of USAID and the executive secretary of UNICEF, giving birth to "selective PHC" low cost interventions, pragmatic and limited in scope[5], which found soon also the needed support in like-minded researchers[6]. This was in line with the advent and prevailing of neoliberal policies and the need to dismantle an holistic proposal with important systemic societal implications. Attention was drawn away from health and focussed on the control of single diseases. Under the strong influence of international organisations and bilateral agencies, this soon resulted in the reorganisation of Health systems in "vertical programs", the disarticulation of public health activities, along with a multiplication of costs and a waste of resources, not to speak of the complete detachment of these programs from development actions being implemented in other sectors (schools, production, etc). This type of approach, disease- rather than health-oriented, was often more consonant with the political and administrative needs of main donor countries and organisations whose influence on choices made by beneficiary countries is well known. It adapted better to market strategies and to "social marketing" and, behind relatively cheap but highly visible campaigns, it often served to mask the lack of any real political will to improve people's health conditions[7].

By 1979 the World Bank had created its own *Population, Health and Nutrition Department* and progressively increased its involvement in the health sector[8]. Beside the financial weight, the World Bank played and increasing role in determining health policies world wide through its influence on developing countries macro-economic policies. Based on its 1987 *Financing Health Services in Developing Countries: An Agenda for Reform*[9] and as an integral part of its "structural adjustment" programmes, the World Bank imposed to developing countries a single recipe Health Sector Reform enforcing fee payment for health services, encouraging privatisation of health services, promoting the introduction of private insurance schemes, and fostering the decentralisation of health care management[10]. Structural adjustment policies imposed on poor countries had been among the main determinants in the worsening of people's living conditions and in the collapse of those health systems, that countries were now asked to reorient.

While the World Bank was heavily occupying the ground, WHO had to face also new financial challenges. In 1982 the World Health Assembly decided to freeze WHO's regular budget. A decision followed three years later by that of the United States to withhold its contribution to WHO's regular budget, in part as a protest against WHO's "Essential Drug Program" which was

opposed by leading US-based pharmaceutical companies[11]. As a consequence the “extrabudgetary” funding started to grow, soon producing a crucial shift from predominant reliance on the regular budget -drawn from member states' contributions on the basis of population size and gross national product- to greatly increased dependance on extrabudgetary funding, i.e “voluntary” contributions from “donor” -rich, industrialised- countries and external contributors as the World Bank. The World Health Assembly had no say over the use of extrabudgetary funds which were pledged by “Donors” according to their own priorities, giving soon rise to a number of vertical programmes, with a variable degree of independence from WHO's institutional decision making structure. By the beginning of the 1990s extrabudgetary funds already represented 54% of WHO's total budget[12].

The increasing influence of the World Bank also coincided with the loss of leadership of WHO. Mahler's tenure was followed in fact by a “dark period” for both WHO and global health[13].

In the 1990s the World Bank started to directly orient the global debate on health. Its *World Development Report 1993*[14] entirely devoted to international health, has been described as a “watershed in international health” giving legitimacy to the Bank in the health sector[15]. The Bank put renewed emphasis on a “selective” approach by means of a "minimum essential package" for the control of a limited number of diseases, and advocated the privatisation of health services, policies that had severe consequences in terms of poorest countries' population reduced access to health services[16].

The World Bank became the largest international donor in the health sector in middle and low-income countries, significantly altering the panorama of international health co-operation. With the size of its operations, the conditions imposed to countries in order to access to credit and the strategies it adopted, the World Bank changed the sectoral priorities and the relationship between donors and beneficiaries both at global and national level[17].

The international health scene was progressively changing. The weak WHO leadership had to deal with an increasing number of players. In addition to the World Bank and other UN organisations, regional development Banks and Funds, the private corporate sector of the great multinational pharmaceutical companies, along with the non-profit-making sector of a growing number of non-governmental organisations, were all claiming a role in the health sector[18]. In the meantime, instead of growing, Official Development Aid decreased by 20% during that decade.

Among the new actors appearing in that period on the global health scene is the billionaire Bill Gates. In 1994, after years of contributing to charitable causes, Bill and Melinda Gates consolidated their giving to address also Global Health and the new William H. Gates Foundation, was formed with an initial stock gift of about $94 million. In year 2000, through further consolidation the Bill & Melinda Gates Foundation will be established, maintaining Global Health among its top priorities[19]. The Bill & Melinda Gates Foundation would soon become the single most important non institutional player on the global field, acting both directly and as a partner of the most important global initiatives.

In the changing scenario, also global public-private partnerships emerged as a new approach to improve the delivery of health services for a number of health problems. Many public–private partnerships were created during the late 1990s, but most were focused on specific diseases such as HIV/AIDS, tuberculosis, and malaria. Notwithstanding the enthusiasm for public–private partnerships, their success in this context appears to be mixed, and few data are available to evaluate their effectiveness[20]. Pretending lack of public resources - where the reality was one of reduced public commitment and of progressive privatisation of international aid - the GPPP model was repeatedly proposed at every Summit as the answer to the most varied and dramatic world problems. Their number increased rapidly surpassing 90 different health-related GPPP, duplicating

interventions and further fragmenting global action for health, with heavy consequences also in terms of health governance, both at national and global level, and provision of health-care in beneficiary countries[21].

Under the leadership of Director General Gro Harlem Brundtland, partnerships and other interactions with the corporate sector started to be promoted within WHO as important shifts in organisational policy[22]. She openly supported the concept and implementation of Global Public Private Partnerships (GPPPs) to face a variety of specific diseases and health issues. Among those she had strongly supported from the beginning the establishment of the *Global Alliance on Vaccines and Immunizations* (GAVI), that was later regarded as a reference for the GPPP model[23], and of the Global Fund to fight HV/AIDS, Malaria and Tuberculosis (GFATM).

Established in January 2000 with the initial five years contribution of 750 millions dollars from the Bill & Melinda Gates Foundation[24], GAVI is focussed on extending the reach and quality of immunisation coverage in developing countries and includes among its partners UN agencies and institutions (UNICEF, WHO, the World Bank), civil society organisations (International Pediatric Association), public health institutes (The Johns Hopkins Bloomberg School of Public Health), donor and implementing country governments, the Bill & Melinda Gates Foundation, other private philanthropists, vaccine industry representatives and the financial community[25].

Since her appointment, Brundtland had addressed the issue of WHO involvement with public-private initiatives, defining the main characteristics these partnerships should have: clear statement of purpose, avoid conflicts of interest, balance of industry and non-governmental organizations' involvement[26]. Considering the difference between the objectives of WHO and those of corporate partners, and the increased dependance of WHO from private funds, Ford and Piedagnél anticipated that those interactions could potentially further reduce WHO independence[27].

In WHO as in general across UN interactions with the private sector had been strengthening during the 1990s. Attentive analysis show that this change within the United Nations and its agencies did not just happen by itself, come out of nowhere or go uncontested. It was strongly debated and largely was a result of constraints in the UN's funding, pressures from some member states and a strong commitment by the Secretary-General, Kofi Annan to take the UN in that direction[28].

More authors would agree that at the end of Brundtland's mandate, WHO's international credibility had been restored, the image and relevance of the Organization at the global level had been successfully improved[29]. However, while the visibility of WHO may have been increased, this did not change the earlier impression that "the WHO was no longer setting the international public health agenda"[30], or that "WHO, once the main player […] is now one of many. Other UN organizations are concerned with health, the private sector has a firm niche with health"[31].

The influence of private foundations (e.g. Bill & Melinda Gates) and public-private partnerships (e.g. GFATM, GAVI) continued to grow, undoubtedly representing the most significant trend in the global health scene. If in some cases they seem having facilitated access at national level to drugs and services for the treatment of specific diseases[32], the fragmentation produced by the increasing number of "vertical" initiatives in the wider context of development aid, their arguable sustainability, the waste of resources due to duplication and lack of alignment to national health plans, gave rise to increasing doubts about effectiveness and appropriateness of that approach, among very diverse observers[33].

Taking her office, the current Director General, Dr Margaret Chan declared that she would be working tirelessly "to make this world a healthier place"[34]. Such an endeavour is strictly linked with the capacity to build social justice[35], ensure full and universal enjoyment of human rights, and

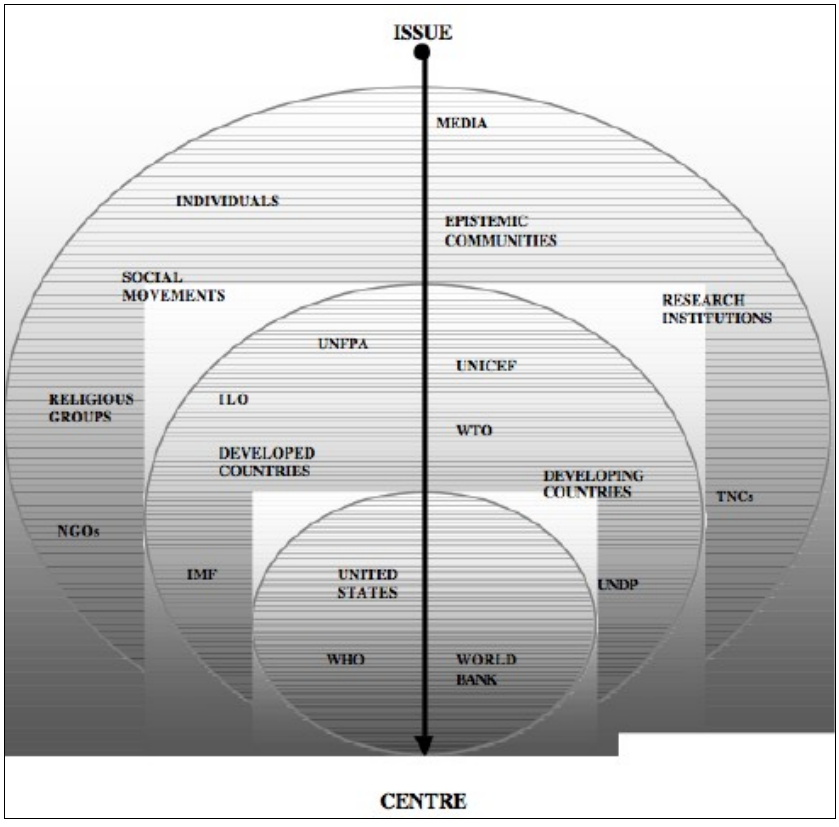
protection of the environment. Such a vision measures development through the improvement of life conditions of those most in need and the reduction of inequalities, rather than indiscriminately through economic growth. In her speech Dr Chan made strong reference to the need for "noble system of ethical values"[36]. Addressing the World Health Assembly after one and a half year in her position, Margaret Chan underlined that "investment in technology and interventions alone will not automatically 'buy' better health outcomes". For the Director General more investment must go into institutional capacity and in systems for delivery; to that effect she insisted on a "return to primary health care", its values, principles and approaches. In the 60th anniversary of the establishment of WHO, she recalled the organisation's mandate to direct and coordinate international health work. Recognising that "WHO is not alone in the drive to improve health", nevertheless unprecedented global interest and investment in health, as well as unprecedented challenges that can only be addressed through well-directed and coordinated global collaboration "gives WHO a clear role"[37] Will this role be put in discussion again? Will there be forces driving against the return to principles and practices of comprehensive primary health care?

The current scenario: interests and players

Along the years a multiplicity of different actors influenced the global health agenda beyond the orientations of the World Health Assembly, each of them accountable to different constituencies and with different agendas.

In a first attempt do define and shape the architecture of Global Health Governance, Dodgson and his collaborators have represented it graphically in progressive circles, according to distance from central "leadership and authority"[38]. In the central circle they put WHO, the World Bank and the USA. We will make reference to their work in trying to update that map.

(Fig. 1 – Global Health Governance Mapped reproduced from Dodgson et al.)



WHO

Due to its mandate WHO formally remains the international health authority at the centre of the graph. The resolutions of the World Health Assembly are not binding, but they still are regarded as a reference for international action, so much that in more than one occasion when a decision was perceived to go against their interests, single member states and/or external actors have acted to derail the decision-making process.
The prevalence in the overall budget of voluntary funds over assessed contributions remains the most visible obstacle to WHO autonomy. In 2006-2007 regular budget represented only 21% of the actual total income of the period, with voluntary contributions that continue to increase: + 58% in 2006-2007 as compared to the previous biennium. While WHO continues to rely heavily on a relatively small number of Member States as a major source of financing of the budget, their relative weight (54% of the total income in 2006-2007, as compared to 71% in the previous biennium) as compared to other sources is decreasing, highlighting the shifting of the Organization's donor base, with an increasing role played by partnerships[39]. The source of voluntary contribution may be changing, but concerns expressed in the past, when extrabudgetary funds constituted just over 50% of the total income, are still valid today. By negotiating bilaterally with WHO, few richer member states, and now powerful external individual donors and alliances, may direct WHO about where the organization's efforts and funds should be spent, by supporting specific programmes and not others, by making ad hoc decisions, rather than developing strategic policies over the longer term, or by supporting fashionable (and changing) priorities rather than developing country needs and preferences. At the same time the some authors have claimed that extra-budgetary funding may undermine the working of WHO's regional structure and relations among the Organizaton's different levels of governance[40]. In an attempt to reduce the high transaction costs linked to the administration of a multiplicity funding sources, WHO has introduced a results-based management approach with an integrated budget, and has introduced the concept of “core voluntary contributions” encouraging donors to provide predictable amounts of funding in alignment with the objectives of WHO's medium-term strategic plan[41]. This may also be the right approach to reduce the potential interference of those funds with WHO activities, however without effect in lowering the industrialised countries' potential, and increasingly of new sponsors, for withdrawing contributions as a tool to put pressure on the organisation if they feel that their interests are at peril.

The World Bank

In May 2007, the World Health Organization (WHO) welcomed the new Health, Nutrition and Population Strategy launched by the World Bank and indicated the strategy, formally approved by the Bank's Executive Board, as a major step forward in supporting poor countries to strengthen their health systems, improve the health services available to people and reduce poverty[42]. In fact with its new strategy the Bank re-focuses on long-term country-driven and country-led support. It decides to look especially for results on the ground, concentrating its contributions on its comparative advantages, particularly in health system strengthening, health financing and economics. Among the initial steps it sees the harmonisation and alignment of international aid and recognises the need to mainstream system strengthening into priority-disease operations, envisaging the establishment of specific agreements with WHO and the Global Fund for “collaborative division of labor” at country level[43]. Leaving areas such as technical aspects of disease control, human resource training and internal organisations of service providers to other organisations (WHO, UNICEF, UNFPA), the Bank seems to be proposing itself as the lead global agency for health-systems policy-development; claiming expertise and credibility in that field that may raise concerns in consideration of past World Bank's role in pushing structural adjustment programs and health sector reforms, that have underpinned many of the current problems in poor countries, as well as the Bank's continued promotion of pro-private market-oriented policies. Those authors conclude that “too much of the bank's strategy is opaque and leaves important questions unanswered”[44]. A former health economist at the World Bank welcomes the new strategy stressing the Bank's unique position to help countries to grow their economies equitably through an inter-sectoral approach. However “with a few caveats” linked to the capacity of the Bank to turn the renewed vision into reality. The Bank “must

pay important attention to the equity implications of its economic policy advice and lending", they stress, and insist on the need to frame health-policy reform in terms of social justice[45]. Whatever the translation into practice of the new strategy, with over 10% of the share of international spending on health, the World Bank undoubtedly remains a central player of global health governance.

The others "H8"

But that centre got more crowded in recent years. New powerful actors stepped in. A new grouping of global actors in health is now identified as the "H8"; besides WHO and World Bank it includes the Gates Foundation, the GAVI Alliance, the Global Fund, UNAIDS, UN Population Fund and UNICEF. Among them the Gates Foundation is the only individual player, as all the others are intergovernmental agencies or otherwise alliances among different subjects, with two of them introducing, with the Gates Foundation, the most striking change in the traditional multilateral architecture, in which UNAIDS possibly represented the first innovation in terms of partnership and wide interagency approach to a health challenge.

The Bill & Melinda Gates Foundation

With a US$1.97 billion outlays for its Global Health Programme[46], in 2007 the Bill & Melinda Gates Foundation surpasses the ODA commitments for health of every single OECD country, but the USA[i].

In addition, thanks to Warren Buffet's US$37 billion contribution to the Foundation's endowment fund, it is anticipated that its annual outlays will increase to about $3 billion[47], undoubtedly classifying the Gates Foundation as one of the most significant contributors to global health.

Channelling its funds through International Organisations, various Global Health Initiatives, research institutes and NGOs, the Gates Foundation obtains seats in a number of governing bodies, so extending its influence into the decision-making process. The Gates Foundation is a fundamental partner and the initiator, of the GAVI alliance, the model Global Public-Private Partnership launched in year 2000.

GAVI

Gates Foundation was in 2007 second only to Norway as a contributor to GAVI; with a yearly US$75 million contribution it represented about 10% of the total resources (US$ 786 millions) made available to the alliance by a total of 12 countries, plus the European Commission, the Gates Foundation itself, and minor private sources. The resources include those committed through the *International Finance Facility for Immunization* (IFFIm), one of the innovative financial mechanisms, established with the financial contribution of 8 countries among which 4 (Brasil, Italy Spain and South Africa) contributing only through IFFIm[48]. GAVI operations will also benefit of the pilot phase of *Advanced Market Commitment* AMC promoted by Italy, UK, Canada, Russia, Norway and the Bill & Melinda Gates Foundation. IFFIm and AMC represent a financing innovation, with pledges of future donations are used to issue bonds on the financial market, allowing money to be spent up front to improve delivery systems, purchase vaccines in larger quantities, and assure manufacturers of a stable long-term market[49].

GAVI has a rather complex governance structure[ii], which makes it difficult to trace the lines of accountability[50]. In the GAVI alliance governing body the Gates Foundation has a permanent seat, alongside three intergovernmental agencies (WHO, UNICEF, World Bank); renewable seats are for both representatives of developed and developing countries (4 seats per group); research

i 2006 data – US ODA commitments for health were US$ 5 billions aggregating Health, Population, Water and Sanitation

ii GAVI Alliance consists of five separate entities, combined under the single leadership of the Executive Secretary and CEO: the GAVI Alliance (unincorporated, Secretariat hosted by UNICEF in Switzerland); the GAVI Fund (incorporated in the United States); the International Finance Facility for Immunisation (incorporated in England and Wales); the GAVI Fund Affiliate (incorporated in England and Wales); and, the GAVI Foundation (incorporated in Switzerland).

community; private industry which, with two seats, has a higher relative weight than civil society (one seat);[51].

The Global Fund to fight against HIV/AIDS, Tuberculosis and Malaria (GFATM)

The Global Fund to fight against HIV/AIDS, Tuberculosis and Malaria (GFATM) is the only other GPPP among the H8. The Gates Foundation has currently a seat also in the GFATM board, but in this case in representation of "private foundations". One of the fundamental objectives at the origins of the Global Fund, was the attraction of additional resources from private sources, and especially from the corporate sector, to the fight of its three target diseases. From this perspective, it was a complete failure. On a total amount of US$ 9.5 billion, contributed in the period 2001-2007, only 4.7% came from non governmental sources and of that percentage 77% in fact from the Gates Foundation. The corporate sector contribution limited to US$ 53 millions deriving from the RED[i] marketing campaign. Notwithstanding, the corporate sector maintains a seat in the GFATM's board. This follows a unique decision-making mechanism. In fact the Board is divided into two "voting blocks". A "donor voting block" with 10 seats (8 country representatives and one seat each for the corporate sector and private foundations). Also the "recipient voting block" has 10 seats; alongside the 7 representatives of Developing countries (divided by regions), three seats are reserved to NGOs from both developed and developing countries (one seat each) and representatives of the "people living with disease". Unlike GAVI, in the Global Fund intergovernmental agencies (WHO, UNAIDS, World Bank) are non-voting members, but the World Bank also serves as the GFATM's trustee[52].

"Donor" countries

Dodgson and coauthors did not put any bilateral donor, but the USA, at the centre of their "Global Health Governance Map"; in their graphic presentation both developing and developed countries are put in a second level of influence[53]. We already mentioned the weight of "donor" countries in influencing WHO through the increasing reliance of that organisation on extrabudgetary funds, and we have seen how a significant number of those countries participate in the governance of GPPPs and obviously in that of other UN entities involved in global health. However, a reduced number of donor countries appear having played a mayor role in modifying the global health governance architecture, consequently acquiring a more influential role, both through their bilateral targetted support to GPPP and/or through the collective action of increasingly relevant international groupings, the most prominent of which is the G8.

The G8

The G8's influence on the global health agenda as a collective body, received an important push in 2000, under Japanese Presidency and increased considerably with the launch of the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria, at the Genova (Italy) summit, the following year. At that time the need for an additional global initiative was still controversial, including among the group of G8 Health experts, who a few months before GFATM was launched still agreed on the inopportuneness of such a targeted initiative[54]. It has been reported that also at a higher political level there was no agreement on the sense of the new initiative and its structure. It has been argued that Italy and others were aligned against the U.S. and those who didn't want GFATM to be run by either the U.N. or World Bank[55]. Some authors have argued that one aim of some proponents of this GPPP has been precisely that: "to undermine the role of the UN system in policy-making"[56].

But an agenda already predetermined at the political level, finally led to the launch of the Global Fund at the G8 meeting in Genova, which would be followed by more or less specific additional commitments in the following years.

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i RED is a brand created to raise awareness and money for the Global Fund by teaming up with the world's most iconic brands to produce (PRODUCT)RED™-branded products. A portion of the profits from each (PRODUCT)RED product sold goes directly to the Global Fund.

Among these the G8 commitments related to polio eradication, to improved access to health care, including to drugs at affordable prices; to research on diseases mostly affecting developing countries; to international co-operation against new epidemics such as SARS; to the establishment of a Global HIV Vaccine Enterprise to accelerate HIV vaccine development; to strengthening health systems (including supply chain management and reporting, and training and retaining health workers); to research, development and production of vaccines, microbicides and drugs for HIV, TB, malaria and other diseases, to innovative clinical research programs, private- public partnerships and other innovative mechanisms[57].
The "full support" to GFATM was repeatedly renewed, but only at the St Petersburg Summit (2006) the G8 agreed to regularly review its work on tackling the three pandemics HIV/AIDS, TB and malaria. The monitoring exercise was undertaken for the first time in view of the Summit of Heligendamm (Germany)[58] and a report was published in October 2007[59]. In Toyako (Japan, 2008) the G8 agreed to establish a regular follow-up mechanism to monitor its progress on meeting its commitments[60].
With its increasing inclusion of health issues in the G8 summit agenda, and initiating initiatives and increasing funding, the group is undoubtedly playing an increasing role in world health governance, whether for good or bad, this is still object of discussions.

Looking for coordination: the International Health Partnership
In any case, the centre of global health governance looks rather crowded and there is need for coordination. In September 2007, recording the delay and declaring the urgent need of getting back on track to reach the health-related Millennium Development Goals, UK's Prime Minister, Gordon Brown, led the launch of a new "International Health Partnership" (IHP), implicitly recognising the failure of an approach based on the promotion of individual initiatives that led to the current hyper-fragmented context. The IHP was signed by the representatives of other seven governments (Canada, France, Germany, Italy, Norway, Portugal, The Netherland) and eleven multilateral partners (African Development Bank, Bill & Melinda Gates Foundation, European Commission, GAVI, GFATM, UNAIDS, UNICEF, UNFPA WHO, World Bank, UN Development Group)[61]. Interestingly, representatives of three G8 countries, notably the US, Japan and the Russian Federation, were not on board.

The IHP aims to make health aid work better for poor countries and accelerate progress by doing three things: providing better coordination among donors; focusing on improving health systems as a whole and not just on individual diseases or issues; and developing and supporting countries' own health plans. The idea is that donor countries and agencies will be working towards providing longer term and more predictable funding to poor countries, so enabling poor countries to make long term plans, in the knowledge that they will have the resources to train new doctors and nurses, pay their salaries, provide medicines and build and maintain clinics and hospitals[62].

The initiative may be welcomed as a positive and needed one. It is in line with commitments previously taken in other international settings, including: the Millennium Declaration, establishing targets to be reached by 2015, and the Paris Declaration[63] with main development actors' commitment organised around 5 key principles: ownership, alignment, harmonisation, managing for results, and mutual accountability. However, besides struggling to bring together into a single framework the many pieces into which the global health scenario has been broken (and many of the "partners" were not extraneous to that result), the new endeavour does not help to re-establish clear responsibility and leadership for global health governance, and in any case leaves out important players.

Conclusions

Since at least the early 1990s, there has been a growing confusion of mandates among the various players with substantial involvement in the health sector within the UN – WHO, UNICEF, UNDP, UNFPA and the World Bank. The latter, nearer to the interests and the vision of industrialised countries and the most powerful bilateral donors, and under their influence, progressively gained a leading role. Reduced support to relevant UN agencies was motivated by loss of confidence in their efficiency and effectiveness. In response, and aiming at regaining position and credibility, as well as at new sources of income, the UN progressively opened it doors to market forces[64]. The new approach soon marked a shift toward public-private partnerships as a "policy paradygm"[65]

By the beginning of the new Millennium a number of new actors had stepped in. While a growing attention for health and an increasing number of global actors contributing to it may be welcomed, the crowded "centre" of global health governance, with players with different interests and powers, also calls for an appropriate framework of global norms and principles, as well as appropriate leadership for their enforcement.

The increasing relevance in the global health scene of GPPP, and in general of the participation of corporations in the policy-making process, raises a number of concerns. GPPPs may have raised the profile of some health conditions (especially infectious diseases) in the global political agenda and eventually contributed to generate additional resources for specific actions, the development of new products and the improvement of procedures, norms and standards in the control of specific diseases[66]. However, on the other side, there are a number of considerable risks. Various observers, including some traditionally not very attentive to health issues, have noted that the recent extraordinary and unprecedented rise in public and private giving is paying for efforts that are largely uncoordinated and directed mostly at specific high-profile diseases, rather than at public health in general and have stressed the existing "grave danger that the current age of generosity could not only fall short of expectations but actually make things worse on the ground"[67]. The risks deriving from fragmentation produced by the mushrooming of vertical initiatives, and doubts about sustainability of that approach have been analysed also by the International Development Agency (World Bank)[68], by the International Monetary Fund[69] and in a research developed by the McKinsey company[70]. Here we are more concerned with the consequences in term of global governance.

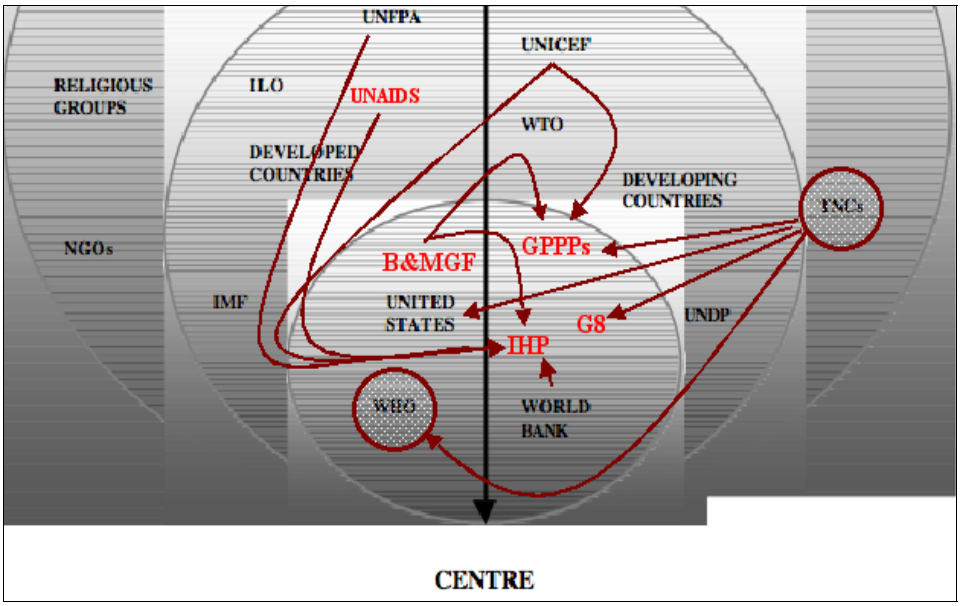
Various authors have pointed out, how legitimacy (GPPPs are not elected and do not represent larger groups of people), representation in governing bodies (biased in favour of the private sector; practical constraints can inhibit weaker actors from truly participating in partnership processes and articulating their interests) and accountability (who is accountable to whom and for what) of GPPPs are at stake also at global level, where they also contribute to procedural and policy-making fragmentation, undermining a comprehensive approach to health, and thus the effectiveness of global policy-making. In addition they compete among themselves and with other agencies in attracting resources distorting financing mechanisms and can be used by powerful actors to circumvent and weaken established organisations like WHO[71]. Finally a number of ethical concerns have been pointed out. Among them, the absence of a framework of global norms and principles within which global public health goals can be pursued in a partnership arrangement; the recalled interference with the mission and organisational priorities of the public sector in conflict with the principle of equity in health; the reduction of the role of the public sector in providing social safety nets resulting in a laissez-faire attitude, prejudicial to the interest of the most vulnerable groups, and conflicts of interest between public health goals and the demand of the private sector for a long term pay off, together with its considerably increased access to policy-making[72].

Global health policy making is increasingly aligned with industrial and trade policies, and is being done hand in hand with business, thus weakening the firewalls necessary for effective regulation and normative actions both at global and national levels[73]. UN and specifically WHO seem having

lost sight of their mission and purpose and fail to take up issues that challenge the profit motives and market logic of the companies. This trend has been especially supported or even induced individually or collectively by a reduced number of countries, the most relevant grouping being the G8. The contribution of the corporate sector and private foundations, that are often their philantropic expression, can be of great value in the fight for health and the improvement of people's life conditions, but to that purpose that contribution should be oriented according to priorities, major strategic decision and approaches selected having in mind exclusively the supreme interest of public health.

The legitimacy and competence to reflect that interest still resides in the World Health Organisation. It is in the interest of the global community to strengthen that UN agency in its capacity to orient and coordinate the overall effort for global health, rather that pushing it into the sole role of provider of technical assistance of new initiatives, alliances and other groupings. Similarly to what some authors argue for multilateral institutions in general, we believe that also WHO leaders and advocates should begin to reconstruct its legitimacy. We also support the "need to recognize how certain aspects of democracy, such as transparency, accountability, and provisions to limit the role of direct coercion, could be incorporated into multilateral institutions, making them more robust against charges of illegitimacy"[74].
We believe that in the interest of "health for all" in the future map of global health governance WHO should be alone in the first circle at the centre of the graph, but with reviewed internal mechanisms to allow wider participation and debate also to non state actors and take full advantage of inputs from actors in more peripheral circles.

(Fig. 2 – Global Health Governance re-mapped)



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