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A global health fund: a leap of faith?
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After the 2000 G8 summit at Okinawa, the leaders of the world’s richest countries announced an ambitious commitment to achieve substantial reductions in the global burden of disease and death due to HIV infection and AIDS, tuberculosis, and malaria by 2010. A new global health fund, to be highlighted at the forthcoming G8 summit in Genoa, could form the cornerstone for meeting this commitment. The fund will be heavily dependent on resources from the richest countries, working in partnership with United Nations’ agencies (especially the World Health Organization), the commercial sector (especially major pharmaceutical companies), other donors, non-governmental organisations, and governments of developing countries. Funds are intended to be additional to existing aid from multilateral and bilateral agencies and will be managed and disbursed by a new entity, the Global Health Fund. This is a major new form of governance (see box 1).

The Global Health Fund follows a plethora of recent global public-private partnerships to promote wider availability of existing products and stimulate product development as well as initiatives with a broader focus on health systems (see box 2). Debates about these partnerships in the past year are relevant to the proposed global fund; they concern issues such as governance structures and functions, the balance of power between partners, the ability of recipient countries to determine how resources are used, and the balance between support to health systems and funding of health products. International policymakers are looking to the Global Alliance for Vaccines and Immunization (GAVI) for lessons, as this is one of the first such partnerships, with an established fund for disbursing free vaccines and funds to support health systems in some countries with a gross domestic product less than $1000 (£714).

Governance

Concerns have been raised about the composition and governance of different global public-private partnerships, including their representative legitimacy, accountability, and competence. In the case of the Global Alliance for Vaccines and Immunization, UN agencies (mainly the WHO and Unicef) have had a dominant role, while commercial representation has been less. Substantial commitments by bilateral donors such as the Netherlands ($100m) and Norway ($125m) have qualified them for seats on the board. Currently, Mali and Bhutan are the developing countries represented on the board; it is unclear how they were selected and how they represent the positions of other developing countries. Only one non-governmental organisation has a seat on the board, raising similar questions.

After a consultation meeting in Geneva in June 2001 there was still “no envisioned structure for the governing board” of the new Global Health Fund, although working papers for the meeting had proposed an executive board of about 12-15 people. It is not yet clear exactly what it will support and how it will be run

Summary points

A new global health fund is being set up to bridge the funding gap for the control of HIV infection and AIDS, tuberculosis, and malaria

The fund is due to be established this year, but it is not yet clear exactly what it will support and how it will be run

The planning burden on developing countries could be increased by the fund if existing global health initiatives are not consolidated and simplified

Rich countries will need to make large, long term commitments to the fund if developing countries are to be successfully supported to sustain new, expensive treatment and preventive services

Box 1: What is the Global Health Fund?

- It is an alliance of partners from UN agencies, developing countries, donor governments, foundations, corporations, and non-governmental organisations
- Its purpose is to mobilise, manage, and disburse additional resources for the control, in the first instance, of HIV infection and AIDS, tuberculosis, and malaria
- It will purchase drugs and vaccines, but there is no consensus on how it will do this or whether it will also support developing countries’ health systems
- Pledged contributions (as of 25 June 2001) amount to $200m from the United States, $180m from the United Kingdom, $150m from France, and $100m from the Gates Foundation. These may be one-off contributions
was proposed that this would represent all constituencies and create a governance structure with executive control over all important functions. Frequent shifts in the proposed focus of the fund suggest considerable contention behind the scenes. It may be that decisions about the governance of the fund will reflect the outcome of a struggle between the major players to determine its focus and control its development.

**Regard to recipient countries’ needs**

Another concern is the interface between the global fund and recipient countries. The UK Cabinet Office Performance and Innovation Unit stated: “Products purchased through the fund should be in response to developing countries’ requests, be suitable for delivery in developing countries and be cost-effective,” reflecting a concern that national policies and priorities could be distorted rather than supported.

Of the 74 countries eligible for support from the Global Alliance for Vaccines and Immunization, by mid-June 25 had successfully applied for support and 20 of these are eligible for new or underused vaccines. Seventeen are planning to introduce hepatitis B vaccine and seven intend to introduce *Haemophilus influenzae* type b (Hib) vaccine to their national programmes (GAVI Secretariat, unpublished article “Global health initiatives—lessons learned from the early days of the Global Alliance for Vaccines and Immunizations (The Alliance), 23 March 2001”). Tensions exist between a supply driven and demand driven approaches. One of the alliance’s targets is that, by 2005, half of the poorest countries with a high burden of disease and adequate delivery systems will have introduced Hib vaccine; however, there is not yet a single fund was being proposed. Competition between priorities, which has been a feature of international health development policies over the past half century, may well continue as other major diseases are proposed for support.

**Balancing systems and product support**

The need for sustainability and for strengthening health systems, especially in the poorest countries, has almost become a mantra in international policy statements. Most recognise that developing countries’ health systems are fragile and yet are central to the delivery of drugs and vaccines. However, there are contested and unanswered questions about improving health systems, not least in relation to the respective roles of the private and public sectors. None of these questions will be resolved in the short term—or in the initial stages of the Global Health Fund. Confusion exists as to whether the fund will support health systems: one report suggests that it should not, whereas another consultation meeting envisaged support for both healthcare commodities and systems. Again the Global Alliance for Vaccines and Immunization provides useful lessons. For recipient countries that are eligible to receive new vaccines and system support, $11.9m or 17% of funds has been allocated to strengthening health systems while the rest is targeted for providing new vaccines. The alliance’s executive director is reported to have said that an opti-
Conclusions

The Global Health Fund is sending out a crucial message that rich countries have a moral and political imperative to do something about three diseases that are wreaking devastation in many poor countries. The fund may underwrite the purchase of drugs, vaccines, and other commodities where markets are too weak to respond and stimulate pharmaceutical companies to conduct research to develop new drugs and vaccines. It is only through a global fund that this kind of concerted global action between major corporate and public sector players can be achieved.

However, there are many challenges in implementing such an initiative. Firstly, the scale of the commitment will need to be sufficient to justify the level of input of international and national policymakers. Estimates of the cost of scaling up existing programmes to tackle the three diseases suggest the need for an additional $9-15bn\(^2\) or $10-20bn\(^3\) annually. Commitments to the fund to date have been small (see box 1). Secondly, considerably greater investment in health systems will be needed to deliver new treatment programmes, whether from the fund or from other sources. Thirdly, if there is a time limit to the international commitment, poor countries that alter their drug policies to incorporate expensive new drugs could be left with unsustainable costs at a future date. Finally, the urgency with which the global fund is now being promoted—to be operational by the end of this year\(^4\)—suggests that the complexities of implementation have been underestimated.

Malaria, tuberculosis, and HIV infection are not new. Now they are finally receiving the degree of attention they deserve, it is important that the goodwill and commitment engendered through this initiative are not lost in failure for lack of attention to making the global fund work well. Achieving good governance for decision making will be the first step.

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