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International Institutions and Global Governance Program

REPORT CARD BACKGROUNDER

Global Public Health

June 2014
This publication is part of the International Institutions and Global Governance program and was made possible by the generous support of the Robina Foundation.

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Global Public Health Governance Grade	C+
U.S. Grade	B

GLOBAL PUBLIC HEALTH GOVERNANCE

Targeting Noncommunicable Diseases	**Average**
The Continuing Battle Against HIV/AIDS	**Good**
Managing Acute Pandemics	**Average**
Addressing Other Infectious Diseases	**Average**
Managing Biosecurity	**Incomplete**
Developing Health Systems in Poor States	**Poor**
Ensuring Global Health Financing	**Average**

CLASS EVALUATION

Leader:	**United States, Bill & Melinda Gates Foundation**
Gold Star:	**World Bank, India, Rwanda**
Most Improved:	**Global Fund to Fight AIDS, Tuberculosis, and Malaria**
Laggard:	**Pakistan**
Truant:	**None**
Detention:	**Syria**

INTRODUCTION

In 2013, global health institutions and international nongovernmental organizations made mixed progress in advancing public health around the world. Domestic efforts were similarly uneven as certain governments launched exemplary public health initiatives within their own borders, while others failed to address national health challenges.

Most positive, state and nonstate actors leveraged extensive resources to confront HIV/AIDS, tuberculosis, and malaria, as well as to expand vaccinations for other infectious diseases. In a notable example, the Bill and Melinda Gates Foundation partnered with JP Morgan Chase to launch the Global Health Investment Fund, which will finance late-stage technologies that have the potential to save lives in resource-poor settings. Additionally, the United States pledged $4 billion to the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which, alongside the contributions of France, Germany, Japan, the Nordic countries, and the United Kingdom, (among others) resulted in a total approximate replenishment of $12 billion over the next three years.

Furthermore, an increasing number of governments expanded or announced new national commitments to health. For instance, Rwanda achieved the steepest decrease in child mortality to date, while the United States worked to implement the Affordable Care Act (ACA), extending access to health insurance (at least in principle) to its entire population. Meanwhile, the eradication of polio in India and China's open and proactive response to contain the spread of a new strain of avian influenza (H7N9) also stood as welcome examples of global health cooperation.

However, political disagreements and structural flaws within the global health architecture complicated efforts by countries and institutions to respond to twenty-first century challenges. Though the World Health Organization (WHO) released a new WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020 [PDF] in May 2013, prospects for implementation did not look any brighter than for the previous 2008-2013 plan. The updated plan called for countries to establish domestic noncommunicable disease goals for 2025, and design strategies to achieve them, but national governments exhibited little interest in incorporating the WHO recommendations. To be sure, the movement toward universal health coverage may potentially improve prevention and treatment of noncommunicable diseases (NCDs), as better access to healthcare could help mitigate both their incidence and severity. Still, this trend is unlikely to fully address the problem without drastically increased resources.

Preparations for managing acute pandemics did not gain momentum in 2013. The World Health Organization released its Pandemic Influenza Preparedness Framework (PIP) [PDF] in 2011, but the implementation of the PIP by member states, whether due to lack of capacity or will, was haphazard. Global performance on addressing infectious diseases was bolstered by China's handling of H7N9, but slow communication about the outbreak of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) highlighted the need to enhance international coordination about the spread of new cases. Countries also failed to make progress on improving biosecurity management in 2013, which remained remarkably anachronistic given continued technological developments.

Emerging powers increasingly emerged as central players in global health. Their efforts to extend health care to their rural populations have increased access to health services for a significant portion of the world's poor, and their growing integration into the global economy has provided

opportunities for them to shape the global health agenda. As the economies of emerging powers expand, so does their capacity to help combat global health challenges. However, progress by emerging powers in addressing the growing prevalence of diabetes and obesity was mixed, and their involvement in international health assistance grew at a slower pace in 2013 than in recent years.

This review identifies five major areas for improvement. First, international and domestic health policymakers should confront the growing global challenge of NCDs with renewed urgency. Second, the international community should support the WHO's efforts to reform its managerial processes and financing system. Third, donors and recipients of health assistance should allocate greater funding to strengthen national health systems. Fourth, developing and developed countries should continue to pursue the goal endorsed by the United Nations of providing universal health coverage to their populations. Finally, targets promoting public health should be part of the post-Millennium Development Goal or "post-2015" development agenda.

BACKGROUND

During the past twenty years, the world has witnessed what experts have correctly termed a "public health revolution." Global health governance—including efforts by states, international and regional organizations, and nongovernmental organizations—has expanded vaccine coverage; significantly decreased mortality due to malaria, tuberculosis, and AIDS-related causes; lowered infant mortality; and raised life expectancy worldwide. The Millennium Development Goals (MDGs), established in September 2000, cemented global health on the international agenda. Three of the eight MDGs address specific health issues—HIV/AIDS, maternal health, and child health—and four others target "social determinants of health." From 1990 to 2010, global health funding grew exponentially, from $5.6 billion to $27 billion, thanks to fresh emphasis placed on health as an international priority and the development of innovative financing mechanisms.

As a result of heightened attention and funding, however, the institutional landscape of global health became increasingly fragmented. The WHO, ostensibly the leader in global health governance, was joined by new multilateral initiatives, public-private partnerships, philanthropic foundations, multinational corporations, and nongovernmental organizations—all dedicated to combating global health problems. Overall, there were more than forty bilateral donors, twenty-five UN agencies, twenty global and regional funds, and ninety global initiatives that target health activities and assistance. Often charged with overlapping mandates, these players jockeyed for finite (and in many cases dwindling) resources to shape the global health agenda and implement programs in the field.

CLASS EVALUATION

The Bill and Melinda Gates Foundation continued to play a revolutionary leadership role in global public health in 2013, contributing unparalleled financial resources to innovative research and programs. As of September 2013, the Gates Foundation had disbursed $28.3 billion in grants since its founding. Among national governments, the United States continued to lead in global health donations, with its contributions to the Global Fund totaling almost $7.3 billion since the Global Fund's founding in January 2002. At the end of 2013 it stood set to retain its historic [PDF] leadership position, thanks to President Obama's pledge to seek $1 from Congress for every $2 committed by other

donors, up to a total of $5 billion. The United States' continued commitment to the Global Fund was especially noteworthy in a year when a budget standoff constrained U.S. government spending on many public programs. The United States' ongoing commitment to helping African states overcome their health challenges was also highlighted during President Obama's summer trip to Senegal, South Africa, and Tanzania, during which he stressed U.S. support for health initiatives.

Gold stars went to the World Bank, India, and Rwanda. In September 2013, the World Bank Group announced a commitment of $700 million in results-based financing through 2015 to help developing countries achieve MDGs 4 and 5 (to decrease mortality rates among children and improve maternal health). In December, the World Bank also joined the Global Fund in a new partnership to help achieve MDGs 4 and 5, as well as incorporate HIV/AIDS, malaria, and tuberculosis services into its projects. World Bank president Jim Yong Kim also prioritized promoting universal health coverage, complementing WHO efforts. For its part, India received a gold star for its successful eradication of polio—a landmark in the fight against the disease. Three years have now passed since that country reported its last case of polio. Finally, Rwanda earned a gold star for achieving the steepest drop in child mortality in recorded history. Over the course of the preceding decade, the country logged an average 11.1 percent annual decline in the probability of a child dying by age five, by expanding vaccine coverage, education, and distribution of mosquito nets, as well as by deploying community health workers.

This year's recipients of most improved were China, for its efforts to contain the spread of H7N9, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria for implementing institutional reforms and a highly successful funding campaign. The Chinese government's delay in reporting the first known human case of H7N9 to the public initially caused some to fear a replay of the China's poor handling of the 2002 outbreak of the severe acute respiratory syndrome (SARS) virus. However, the government's response in 2013, from surveillance to treatment to preventive measures, was much improved. Some concerns remained regarding the transparency of reporting by local and provincial officials, but China's track record over the past year bodes well for the continued containment of the virus. The Global Fund also merited mention as most improved for the significant reforms it undertook during the year, including a new funding model, which helped the Global Fund secure $12 billion in commitments for the next three years at its fourth replenishment. These achievements came only two years on from the 2011 corruption scandal involving allegations of fraud among aid recipients, which drew needed attention to managerial and financial governance problems.

Pakistan earned the designation of laggard in 2013 because of a 28 percent rise in the number of polio cases. Cases of the disease in the country jumped from sixty-five in 2012 to ninety-one in 2013—a 28 percent surge. The rise was attributed to the government's hurried and poorly coordinated implementation of a 2011 decision [PDF] to devolve health care governance to the provinces. As a result, disease surveillance and vaccine coverage [PDF] faltered in several provinces, for measles as well as polio. Furthermore, the government failed to ensure the anti-polio campaign's perceived legitimacy in the aftermath of the hunt for Osama Bin-Laden, which involved the creation of a fake vaccination program in Pakistan by U.S. intelligence officials. The government also proved unable to protect vaccination workers from violent attacks by the Pakistani Taliban in 2013. Pakistan's struggles endangered the international effort to eradicate the disease globally. At year's end, the disease had infected nine "previously polio-free provinces" in Afghanistan.

Though some observers traced the origins of Syria's polio outbreak to Pakistan, the government of Syria landed in detention for counterproductive behavior in response to the disease. Polio was

eliminated in Syria in 1995 but reemerged in 2013 as a result of the civil war and the decline in the vaccination rate. The scope and severity of the outbreak were exacerbated by the actions of President Bashar al-Assad's government, which withheld sanitation services and vaccines from areas where opposition movements were strong. The Syrian government was slow both in acknowledging the first cases of polio in 2013 and in starting a nation-wide vaccination campaign to respond to the outbreak.

U.S. PERFORMANCE AND LEADERSHIP: B

In 2013, the United States continued to demonstrate leadership on global health, but principally did so by maintaining past commitments rather than spearheading new initiatives.

The President's Emergency Plan for AIDS Relief (PEPFAR) approached its ten-year anniversary [PDF] and by December 2013, PEPFAR had provided a total of 6.7 million patients with critical treatment. PEPFAR funding suffered as a result of sequestration however, which imposed a roughly 5 percent budget cut [PDF] on FY13 global health funding and also decreased funding to USAID's global tuberculosis program and the Centers for Disease Control and Prevention (CDC)'s Division of Tuberculosis Elimination.

More positively, the Global Fund to Fight AIDS, Tuberculosis, and Malaria saw its funding grow from the previous fiscal year despite sequestration, and the United States remained the international leader in cumulative contributions to the Global Fund in 2013. The President's Malaria Initiative (PMI) also reported [PDF] in April 2013 that an additional allocation worth $30 million enabled it to remain active despite a plateau in overall funding since the global financial crisis

The United States also demonstrated leadership in the fight against counterfeit drugs and efforts to improve regulation along the global supply chain for medicines. In June 2013, the U.S. Food and Drug Administration partnered with foreign counterparts to shutter 1,677 illegal pharmaceutical websites and confiscate over $41 million in counterfeit medicines—an example of increased attention and strong U.S. leadership on the issue, despite the relatively small dent it made given the extent of the counterfeit medicine problem.

U.S. progress in establishing a strong framework to fight pandemics was largely limited to preparations for the 2014 launch of the Global Health Security Agenda [PDF], but experts expressed hope that this initiative would facilitate better coordination by the U.S. government and its partners as they respond to infectious disease threats. Implementation of the National Health Security Strategy (NHSS) to prepare for a health emergency also appeared to be proceeding. The U.S. Department of Health and Human Services solicited public input on the upcoming NHSS revision via the National Heath Security Strategy Stakeholders Meetings—though the first report detailing the strategy's progress will not be submitted to Congress until December 2014.

More troubling, the country maintained its historic ambivalence on several critical aspects of global health. First, noncommunicable diseases remained the leading cause of death and disability in most low- and middle-income countries but were not mentioned in the president's FY2014 budget request [PDF] (released in April 2013), which sought more than $10 billion for global health related accounts. The United States also failed to take domestic legislative action to arrest climate change, which is exacerbating public health challenges around the world, such as dengue fever and malaria.

The replacement of the defunct Global Health Initiative with the Office of Global Health Diplomacy (OGHD) provided a measure of optimism regarding the administration's commitment to

pushing forward on improving interagency coordination on global health, but the OGHD's success depends on access to scarce political resources and its efforts may prove difficult to evaluate. The administration's delay in nominating a replacement for the Global AIDS Coordinator, Ambassador Eric Goosby, by the year's end also appeared to indicate that the Obama administration was not prioritizing global health.

More broadly, the Obama administration's top health priority was understandably domestic as it sought to launch the Affordable Care Act (ACA), which aims to extend health insurance to all U.S. citizens. Although the implementation of the ACA gathered momentum by the end of 2013 despite its chaotic rollout, many U.S. policymakers remained ambivalent about extending care, which further undermined the U.S. capacity to support the global campaign to expand universal health coverage.

TARGETING NONCOMMUNICABLE DISEASES: AVERAGE

Progress in tackling the challenge posed by noncommunicable diseases was largely concentrated at the national level, even as the incidence of NCDs continued to increase. NCDs—such as diabetes, cancers, cardiovascular diseases, and chronic respiratory diseases—kill more than 36 million people each year [PDF]. And yet the major source of funding to combat these illnesses remains private: a report released in 2013 found that almost half of all funding to counter NCDs internationally resulted from the generosity of a single philanthropic organization, the Bloomberg Family Foundation. Furthermore, in July 2013, reports emerged that Mexico had overtaken the United States as the country with the most obese population, and by September 2013, China's diabetic population had surpassed that of the United States. Indeed, approximately 86 percent of all deaths from NCDs take place in low and middle-income countries, highlighting that they no longer plague developed countries disproportionately.

Official development assistance to address NCDs remained unchanged two years on from the UNGA high-level meeting on the topic, and WHO spending on NCDs and their risk factors still accounted for only 6 percent of the WHO budget approved in May 2013. The World Health Assembly (WHA) did vote to increase the percentage of funding devoted to NCDs, but only by shifting funds away from some infectious disease programs. The WHO also sought to address NCDs in the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020 [PDF], which was released in May 2013 and earned the endorsement of the sixty-sixth WHA. The new plan was designed to replace the WHO's 2008-2013 NCD action plan, which expired in December and articulated strategies to prevent, monitor, and manage NCDs. The new plan laid out policy options for implementation, as well as an international monitoring and reporting system. However, containing the spread of NCDs and providing adequate treatment will still require increased funding and global cooperation to address the role of the private sector.

Meanwhile, some countries made significant strides individually. Egypt, for example, addressed the prevalence of diabetes [PDF] (even in the midst of political upheaval) and both South Africa and Sierra Leone released strategic plans for NCD prevention and control. Emerging economies in particular, have seen the prevalence of NCDs surge, though their domestic responses to NCDs varied. In 2013 for example, Brazil remained far more committed to responding [PDF] to obesity and diabetes than did China or India.

Tobacco use is one of the main risk factors for NCDs as acknowledged in the 2011 political declaration of the UNGA. Implementation of the Framework Convention on Tobacco Control continued

to languish in 2013, and the lack of U.S. enthusiasm for the accord (which it has never ratified) only undercut its legitimacy more. In addition, concerns grew in 2013 that a U.S. proposal for the Trans-Pacific Partnership could hinder the efforts of low and middle-income countries to enforce anti-tobacco laws and implement policies to reduce use by facilitating the circumvention of anti-tobacco laws.

The role that private companies, such as tobacco companies and multinational national food and beverage companies, play in combating NCDs remained controversial during the year. However, WHO director-general Margaret Chan made clear in May that while the WHO will not partner with the tobacco industry, it will accept donations from and enter into partnerships with food and beverage corporations. Furthermore, the WHO's 2013-2020 NCD action plan highlighted the role of multi-sectoral partnerships [PDF].

THE CONTINUING BATTLE AGAINST HIV/AIDS: GOOD

In 2013, HIV/AIDS received significant attention from international public health initiatives and development institutions, which translated into measurable progress. In particular, the Gates Foundation, the United States, and the World Bank continued to allocate financial resources to efforts ranging from the Global Fund to PEPFAR to UNITAID.

Throughout 2013, these efforts continued to yield results. In September, the United Nations announced that mortality rates from AIDS and HIV infection were decreasing significantly worldwide, and the number of patients receiving treatment was rising. New figures showed that the number of AIDS-related deaths globally peaked in 2005 at 2.3 million, fell to 1.7 million in 2011, and declined to 1.6 million in 2012, with a further decrease projected for 2013. Remarkably, the annual report of UNAIDS declared that it would likely reach its goal of providing HIV treatment to fifteen million by 2015.

A major milestone came in December 2013 when worldwide donors committed $12 billion to replenish the Global Fund. U.S. president Barack Obama confirmed that the administration will continue to seek $1 from Congress for every $2 committed by all other international donors to the Global Fund over the next three years, up to the maximum allowed contribution of $5 billion. Though donors unfortunately did not pledge enough to trigger the maximum contribution from the United States, the 2013 replenishment still enabled the Global Fund to expand its lifesaving work. As of August 2013, this had included grants totaling approximately $23 billion for over one thousand programs in 151 countries worldwide. President Obama's pledge followed an announcement by U.S. secretary of state John Kerry at the UN General Assembly in September of new PEPFAR "Country Health Partnerships" with Namibia, Rwanda, and South Africa. These country-specific plans seek to advance a critical public health goal: strengthening health governance in developing countries to improve accountability and establish more sustainable health programs, though details on the specific architecture of these partnerships had not been released by late 2013.

National initiatives undertaken by some emerging powers also contributed to the global fight against HIV by expanding access to treatment domestically. Brazil continued its innovative leadership on this issue by launching a new program in partnership with the United Nations Office on Drugs and Crime (UNODC) to expand the supply of rapid HIV tests to vulnerable communities. Indonesia also committed to a significant expansion of HIV prevention, testing, and care services to counter its rising infection rate. The launch of these new national programs demonstrated that some

governments are striving to complement international efforts to combat HIV/AIDs with domestically led programs.

MANAGING ACUTE PANDEMICS: AVERAGE

During the year, cooperation to confront pandemics varied, as implementation international mechanisms for pandemic cooperation flagged, but China communicated more openly about the H7N9 virus.

2013 saw a record number of virulent avian flu virus variants, including H7N9, H3N2, H10N8, and mutated forms of H5N1, whose transmission mechanisms remained poorly understood. Surveillance and response capacities also still varied considerably [PDF] among countries and nearly half of WHO members continued to lack adequate detection capabilities. Moreover, international procedures for coordinated pandemic prevention, detection, and response remained incomplete in 2013, which added to the difficulty of implementing the 2005 International Health Regulations (IHR). Six years after the revised IHR came into force, 80 percent of IHR signatories had failed to meet their international legal obligations to implement the regulations. The WHO published new guidance [PDF] on pandemic preparedness in June 2013, and some countries have made progress [PDF] in increasing their capacity to detect and respond to diseases under the IHR framework, but numerous national governments have yet to establish adequate systems for monitoring outbreaks, assessing risks, and coordinating responses to pandemics. Acknowledging the failure by the majority of countries to meet the WHO's June 2012 deadline for developing IHR core capacity requirements, the United States devoted resources in 2013 to the 2014 launch of a new global health security agenda that should improve coordination on infectious disease threats.

Meanwhile, over fifty cases of Middle East Respiratory Syndrome (MERS) appeared in countries ranging from Saudi Arabia to Germany to the United Kingdom. Understanding the scope of the threat posed by the virus—which had a fatality rate of 60 percent in Saudi Arabia in 2013—was made more difficult by the Saudi government's initial withholding of information regarding the spread of the disease. The government's slow reporting highlighted the need for health officials worldwide to investigate [PDF] quickly and communicate clearly with the WHO when faced with a possible infectious disease outbreak.

On the other hand, China took swift action in response to the first cases of H7N9 in February 2013. This demonstrated the extent to which China has improved transparency and strengthened its response capacity since the 2002 SARS epidemic by instituting a new threat detection program, significantly expanding the number of influenza surveillance laboratories, and establishing more efficient mechanisms for reporting to the WHO, among other reforms. As the H7N9 outbreak spread in 2013, Chinese authorities shared information [PDF] with international organizations and other countries as they obtained it, allowing for crossborder collaboration to control the outbreak. For example, the U.S. Centers for Disease Control and Prevention (CDC) coordinated with its Chinese counterpart in order to rapidly develop H7N9 diagnostic test kits.

In terms of preparing for an influenza pandemic, the World Health Organization's Pandemic Influenza Preparedness Framework [PDF] (PIP) continued to serve as a focal point of international coordination, but inconsistent implementation of the framework by member states persisted. Funding for the PIP also remained limited. A revision of the 2013-2016 Partnership Contribution Implementation Plan [PDF] increased funding to the PIP secretariat, which was a positive step, but cooper-

ation with pharmaceutical companies—crucial actors in pandemic preparedness—languished. States expressed their frustrations [PDF] at the May 2013 WHA meeting that the WHO had not struck more agreements with major pharmaceutical manufacturers to expand vaccine and antiviral medicine production, lower prices, and increase donations to stockpiles.

Ultimately, policymakers failed to make progress during 2013 on formalizing [PDF] international norms to facilitate crossborder sharing of samples of lethal pathogens. This issue has been the subject of considerable debate, particularly given national disparities in the ability to manufacture and distribute vaccines. Some officials anticipate that they will not benefit from vaccines manufactured abroad and argue that sharing samples may therefore undermine national security—a trend that does not bode well for global cooperation on pandemic preparedness and response.

ADDRESSING OTHER INFECTIOUS DISEASES: AVERAGE

Emerging powers made important progress in confronting the challenge of other infectious diseases, while other developing countries struggled to contain resurgent threats. To support developing countries' efforts, donors continued to expand vaccine coverage, but momentum to meet commitments waned in some important areas.

A milestone in public health occurred in 2013 with the successful eradication of polio in India. The country logged its third year since the last case of polio was reported there. Moreover, in April 2013, the Global Vaccine Summit in the United Arab Emirates attracted a significant commitment of $4 billion for the Global Polio Eradication Initiative. The Bill and Melinda Gates Foundation also reported notable success in Nigeria, where the number of new polio cases dropped by 65 percent.

However, sustaining this success might be jeopardized, as vaccination coverage campaigns in Nigeria stagnated [PDF] in 2013, largely as a result of security problems and political upheaval. Vaccination programs in Pakistan stalled for similar reasons, while in Somalia, poor coordination in response to a May 2013 outbreak was exacerbated by al-Shabab's refusal to allow one million children to be vaccinated, leaving the Horn of Africa vulnerable to the spread of the virus. Polio found in environmental samples in Israel also posed a serious risk to nearby countries that lacked Israel's comprehensive vaccine coverage and sewage surveillance system. Even more troubling was the necessity for the UN to launch a new initiative to provide twenty million children in Syria (an area confirmed to be polio-free in 1999) with polio vaccinations due to a confirmed outbreak in September 2013.

For its part, the Global Alliance for Vaccines and Immunisations (GAVI)—one of the major international public-private health partnerships—achieved mixed results. The alliance announced that it was within reach of meeting the goal of its 2011-2015 strategy— to vaccinate 243 million of the poorest children by 2015. GAVI also announced that it was set to receive 100 percent of "cofinancing payments" from developing nations that have pledged to help GAVI cover the cost of vaccines. By August, sixty-four of the sixty-seven cofinancing states had delivered on their pledges for 2012, and from 2011 to 2013 these commitments amounted to $125 million. In addition, 2013 marked the launch of a new five-year vaccine investment strategy that included potential support for a malaria vaccine. And yet, at the same time, the introduction of vaccines in some countries had fallen behind already established goals. By October 2013, GAVI announced that it was not on track to achieve its targets regarding health system strengthening nor was it set to extend coverage for the three doses of diphtheria-tetanus-pertussis vaccine (DTP3) as it had envisioned.

In a positive development, countries and institutions made progress in confronting neglected tropical diseases (NTDs), which wreak disproportionate havoc on some of the most vulnerable populations in the world. On December 6, 2013, the WHO announced that it could certify five additional countries—Ivory Coast, Nigeria, Niger, Somalia, and South Africa—were free from dracunculiasis (guinea-worm disease). Furthermore, in May 2013, the World Health Assembly produced a resolution [PDF] that called on members to guarantee country ownership of preventing, controlling, and eliminating NTDs; expand interventions; and provide universal access to interventions.

More concerning, states took no major action to combat anti-microbial resistance (AMR) whereby disease-carrying bacterial organisms become progressively less sensitive to anti-microbial medicines. Despite receiving greater attention in some high-profile settings [PDF] such as the World Economic Forum, no concerted effort to coordinate government action on a global scale emerged, especially with respect to removing disincentives for innovation by the pharmaceutical industry. The WHO did form a Strategic and Technical Advisory Group on Antimicrobial Resistance in September 2013 to advise the WHO on a global strategy for fighting AMR, but the impact of this step remained to be seen.

MANAGING BIOSECURITY: INCOMPLETE

National and multilateral efforts to prevent infectious diseases from being intentionally released into communities were outpaced by the growing number of risks. The primary international mechanisms to manage biosecurity are the Geneva Protocol of 1925 [PDF], which forbids the use of biological weapons by states, and the 1972 Biological and Toxin Weapons Convention, which prohibits countries from developing, producing, and stockpiling biological weapons. Four new states joined the BWC in 2013 but both accords still lacked universal participation and the means to enforce compliance. UN Security Council Resolution 1540, intended to counter WMD terrorism, helped to address this gap; the resolution includes biological agents among the WMD materials states are required to prevent from falling into the hands of nonstate actors. In October 2013, the United States filed its fourth report to the 1540 committee, indicating that it had implemented mechanisms to ensure all of its obligations under Resolution 1540 would be fulfilled. By that month, approximately 170 countries had also filed national implementation reports with the committee, but these did not generate momentum to address security gaps.

On the whole, international efforts to manage biosecurity were thin during 2013, even as technology increasingly raised the risk that a lethal pathogen could be manufactured and unleashed into communities. Consequently, the small and disparate bilateral initiatives, such as a joint U.S. State Department and Department of Defense program to enhance the Iraqi government's biosecurity practices, remained dangerously insufficient [PDF]. Moreover, the risk posed by "dual-use" medical research materials also continued to grow, as technological advances in three-dimensional printing and synthetic biology increasingly outpaced regulatory frameworks.

DEVELOPING HEALTH SYSTEMS: POOR

The international effort to strengthen domestic health systems in order to better meet the needs of populations continued to be impaired by reluctance on the part of donor nations to invest in the public health infrastructure of developing countries. According to the most recent figures, 80 percent of aid from leading bilateral and multilateral donors to fragile states still sidestepped the local public

sector and its composite institutions. Resource-poor settings are often plagued by problems ranging from understaffing to a lack of access to vital medicines. Still, policymakers too often ignored the need to place the infrastructural inadequacies of developing states' health systems in the broader context of state fragility.

To be sure, the challenge of improving health systems was not limited only to international efforts to assist developing countries: The United States, which boasts the world's largest economy, only passed legislation to extend health coverage to virtually every American citizen in 2009, and implementation of that effort proceeded unevenly in 2013.

Despite these challenges, some bright spots emerged in 2013. World Bank president Jim Yong Kim announced a new target: to halve the number of people impoverished by medical expenses—approximately one hundred million each year—with the ultimate goal of eliminating the problem by 2030. Together with the WHO, the World Bank also announced plans to double access to basic health services such as vaccinations, and to expand delivery of these services to 80 percent of the poor in developing countries by 2020.

Since the WHO published its pathbreaking report on universal health coverage in 2010, the governments of several countries—including Chile, China, India, Indonesia, Mexico, and Rwanda—have expanded (or continued to expand) health coverage to their populations. Rwanda attracted international attention in December 2013 for logging the most dramatic decrease in the rate of child mortality in recorded history, thanks to the efforts of a system of community health workers. Rwanda's success tracked with the broader trend toward lower child mortality rates globally. In September 2013, the United Nations Children's Fund (UNICEF), the WHO, the World Bank Group, and the United Nations Department of Economic and Social Affairs/Population Division released a report that found that the number of child deaths worldwide had dropped by nearly half since 1990. More generally, a March 2013 report [PDF]from the African Development Bank argued that healthcare systems across Africa have "reached a turning point," and that Ghana, Ethiopia, Nigeria, Rwanda, and South Africa have made particular strides toward achieving national health insurance policies. For example, Ethiopia sought to expand access to health services in rural areas, where health care has traditionally been substandard or absent, and by June 2013, the country had deployed more than 38,000 health extension workers.

Overall, however, donor support for public health remained overwhelmingly disease-specific. Data suggested that progress toward the health-related Millennium Development Goals (MDGs) was uneven not only across states but within states [PDF].

ENSURING GLOBAL HEALTH FINANCING: AVERAGE

Despite renewed pledges to fund global health initiatives in 2013, the WHO continued to face budget constraints and the majority of international financing was targeted for unsustainable programs that target specific diseases without bolstering health care delivery services more broadly.

One partnership launched between JPMorgan Chase and the Bill & Melinda Gates Foundation was the Global Health Investment Fund, which will invest in expanding access to certain drugs, vaccines, and other "late-stage technologies." It procured $94 million in pledged funds from groups including the Children's Investment Fund Foundation, Grand Challenges Canada, and the German Ministry for Economic Cooperation and Development. The initiative promised to provide vital care in some of the most vulnerable countries.

Additionally, for the first time in the World Health Organization's history, the World Health Assembly approved [PDF] the program budget for 2014–2015 in its totality. The vote was notable because it included reforms to the structure of the organization's financing that gave the WHO more discretion over allocating funds within its budget (as opposed to being dictated by major funders' priorities). The WHO, however, remained constrained by the insufficient assessed contributions and earmarked voluntary contributions of member states. Further reforms, as well as the Financing Dialogue—a mechanism to mobilize contributions from member states and external donors launched in June 2013—may help ease these constraints.

President Obama also committed the United States to contribute up to $5 billion over the remainder of his term to the Global Fund to combat HIV/AIDS. Ten other governments, including those of Japan, Germany, France, the Nordic countries, and the United Kingdom, among others, made their own commitments, amounting to an approximate total pledge, including U.S. contributions, of $12 billion [PDF] to the Global Fund over the next three years.

At the same time, the vast majority of global health financing remained earmarked for fighting specific diseases, obscuring the importance of strengthening health systems to improve prevention and treatment more comprehensively. Though many of these efforts have yielded substantial results, sustainable progress requires stronger health systems, which in turn requires additional funding. The fact that health financing is still excessively dependent on the United States, which provides more than 60 percent of all publicly-derived funding for HIV, remained worrisome. Sustaining programs over the long-term will require considerable diversification of funding sources for global health. Emerging powers are increasingly expected to help fill this gap, but in 2013, they did little to remedy this imbalance. Brazil in particular, which in recent years has assumed a more prominent role in financing health-related initiatives in the developing world, retreated somewhat, failing to keep up with its promised contributions to the World Bank's International Development Association.

AREAS FOR IMPROVEMENT

The existing regime governing global public health requires improvement in five major areas:

- The 2011 UN resolution on NCDs helped increase attention on the fight against NCDs, but existing donor funds, priorities, and initiatives—both multilateral and bilateral—should be better aligned with NCDs' growing disease burden. Individual efforts should be harmonized to maximize their effectiveness. Advanced economies should also expand technical cooperation to help guide the efforts of low and middle income countries, as they increasingly grapple with the massive scope and complexity of NCDs.
- The WHO must be enabled to implement meaningful reform to effectively safeguard global health. Countries—developed and emerging powers in particular—need to support the reform agenda to ensure that the body retains its effectiveness in the face of twenty-first century health crises. Specifically, they should push to implement the recommendations of the November 2013 independent evaluation, including further honing priorities to maximize impact, better aligning secretariat resources to a country's health needs, and increasing accountability. In turn, member states should commit to reinforce the organization through adequate financing.
- Health funding from developed countries continues to be disproportionately channeled toward disease-specific initiatives rather than for national health systems strengthening.

However, low and middle income countries require greater funding for national health care systems to improve the health of their populations over the long-term. Forging consensus around what constitutes "health systems strengthening" among donors and recipients will facilitate this goal. To achieve this, global health funding must diversify. Therefore, emerging powers should step up contributions to reduce overdependence on the United States and a select few private groups and also focus on financing health systems.

- Countries should heed the call of the WHO and the United Nations General Assembly to provide universal health coverage (UHC) to their populations. Given resource constraints, policymakers should adopt innovative and flexible approaches, such as public-private partnerships and community-based health care models. Developing countries such as Nigeria and Rwanda should bolster knowledge-sharing about their experiences, while emerging markets such as China, South Africa, and Turkey, which have made great strides in extending primary health care coverage, should continue to lead by example and share best practices.
- As the United Nations debates the post-2015 development agenda, countries should strive to include targets promoting public health. Negotiators should set an agenda that includes specific health targets that will ensure the achievement of Millennium Development Goals four through six, framed within a broader goal focused on expanding universal health coverage and narrowing gaps in mortality rates between developed and low and middle-income countries.