International Health Cooperation in China

Yan Wang

Regional Outlook
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About the Author

Yan Wang

Ms. Yan Wang is a PhD candidate in the Centre of Environment and Population Health at Griffith University. Her research concerns international cooperation on public health, particularly in HIV/AIDS prevention and control in China. As the holder of an Australia–China Futures Dialogue Visiting Fellowship 2010, she took up 12 weeks research at School of Public Health, Peking University. During her time at Peking University, she attended research workshops and seminars on health policy and health reform, and interviewed many key informants from various organisations, all of which make a valuable contribution to her current and future research. Yan Wang has a Masters Degree in Public Health from the University of Wollongong, and worked in the Department of International Cooperation in China’s Ministry of Health before engaging in her PhD studies.
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As global public goods, health problems transcend national boundaries. They can be influenced by circumstances or experiences in other countries, and addressed by international cooperative actions and solutions. International cooperation on health is inarguably a powerful tool for the management of global health. For developing countries like China, such cooperation has played an important role in health development.

With rapid change in our globalised world, international communities and their partner countries have become highly aware of issues related to the harmony and effectiveness of international cooperation on health. There is, however, little substantive information for researchers and project managers on how best to manage the challenges posed by international cooperation, particularly in a country like China which has nearly a quarter of the world’s total population.

This paper examines international health cooperation globally, and for China particularly, to provide information for international communities and their partner countries. It seeks to improve the harmony and effectiveness of international health cooperation from its foundations in order to develop specific policy actions. The paper reviews international cooperation on health, analysing its history and current trends, its importance and influencing factors, and the main players and challenges, particularly in China. Based on an extensive literature review and face to face interviews, this paper begins with an overall picture of global international cooperation on health, then analyses the current situation of international cooperation conducted in China. It outlines the benefits, needs and opportunities of international health cooperation in China and finally explores the major challenges this entails.

The paper can be used as a resource for international cooperation on health for the growing numbers of public health professionals who are exploring issues related to international health cooperation. It also serves as a common platform for discussing the current situation and possible new directions for international health cooperation, particularly in China, and provides a body of useful knowledge and possible solutions for policymakers, researchers and international partners alike. The findings suggest as the next step conducting a further and more in-depth study of strategies necessary to address the influencing factors identified in this study, in order to enhance international health cooperation by Chinese agencies.
1. Introduction

International cooperation plays a crucial role in public health. The successful eradication of smallpox is an example of what can be accomplished through deliberate national and international cooperation. However, with the world changing rapidly and so many players involved in international health cooperation, issues such as overlapping mandates, competition and duplication have emerged. This paper aims to review international health cooperation globally and in China, identify the main challenges, and discuss some possible solutions for future development.

As the world is increasingly becoming a global village, health can be seen as a global public good. These goods are defined as outcomes or intermediate products that trend towards universality in the sense that they benefit all countries, population groups and generations. No individual or country can fully guarantee its own health. Health problems transcend national boundaries, and they can effect, and are influenced by, circumstances or experiences in other countries. They are best addressed by cooperative actions and solutions.

International cooperation on health has a long history and its development has changed rapidly since the final quarter of the twentieth century. In the context of globalisation, health inequality, foreign policy and global health security, such collaboration is more vital than ever, bringing benefits to both developed and developing countries. At the same time, however, the rising number of international health players has created a challenging environment for those seeking to harmonise and align efforts. Discussing past and present trends in international health cooperation, understanding its benefits and the factors that influence it, identifying the roles and limitations of the main players in international health cooperation, and analysing the issues raised by the complex circumstances of international cooperation for health can help international communities and their partner countries to make sounder decisions and achieve more sustainable development strategies.

Nowadays many international cooperative programs are implemented in China, and the trend of international cooperation on health is increasing. For a lower-middle-income country like China, international cooperation on health is needed to achieve equitable national development and growth, as well as to help China adopt international norms, meet global standards and contribute to critical areas for international cooperation. Though the current political environment and commitment to address health has created unprecedented opportunities for international health cooperation, many challenges are emerging with the rapid changes in China. Furthermore, as China has become an increasingly important part of global health over the past several decades, interest in China’s international health cooperation has increased among public health professionals internationally and in China. Thus, review and analysis of international cooperation in China is timely and necessary for removing barriers and successfully implementing these cooperative health programs.

Despite growing recognition of the importance of international cooperation for health in our interdependent world, current research on this topic is insufficient, particularly in China. There is a huge supply of published sources concerning international cooperation on health, but most writings focus mainly on aspects of disease control. Little scholarly consideration has been given to how twenty-first century international cooperation for health should be managed through collaboration between different players. In China, most articles regarding international cooperation on health concern aspects of social science; little scholarly attention has been paid to international health cooperation as a matter of public health. To address the gaps from failure to identify the challenges arising from cooperation between different players in the international health
cooperation literature, and to examine the functions of international health cooperation from the public health angle, it is necessary to conduct in-depth analysis to explore these challenges, in order to learn about and test strategies of international health in China.

This paper begins to fill the shortfalls in the study of international health cooperation by reviewing the literature on international cooperation for health. This paper analyses the history, current trends, importance and influencing factors in this area, it examines the main players and challenges, and focuses particularly on China. The review is expected to be a useful resource concerning international cooperation on health for the growing numbers of public health professionals who are exploring international health cooperation. It is intended to help form the foundation for developing specific strategies for international communities and their country partners.
2. Methods

This paper is based on a systematic literature review and face to face interviews. Main findings are presented in the sections that follow.

The literature review aims to identify and examine the situation and issues relating to global and Chinese international health cooperation, particularly regarding HIV/AIDS issues. The extensive sources of data include books, journal articles, government documents, policy reports and conference papers. The books are related to health, public policy and international cooperation. The journal articles concern all of this paper’s research areas. Government documents come from Chinese government agencies, e.g. Ministry of Health; the government agencies of other nations, such as USAID, UK Department for International Development; United Nations, and other international agencies such as the World Health Organisation and the World Bank. All of these government materials are published studies and research reports. Policy reports and presented papers, especially from the Chinese archival literature, have also been reviewed to trace the actions and strategies of international health cooperation.

Empirical information is from face-to-face interviews. From September to December, the author participated in the ‘2010 Australia China Futures Dialogues Visiting Fellowship’ at the School of Public Health in Peking University. During her visit to Beijing, she conducted face-to-face interviews with 14 key informants including government officials, medical professionals, representatives of international organisations in China, a non-government worker, and a scholar from a research institute. Details of these key informants are listed in Table 1.

Table 1: Details of Key Informants

<table>
<thead>
<tr>
<th>Positions</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government officials from Chinese MOH*</td>
<td>2</td>
</tr>
<tr>
<td>Medical professionals from China CDC**</td>
<td>4</td>
</tr>
<tr>
<td>Representatives from international organisations</td>
<td>WHO (3)</td>
</tr>
<tr>
<td></td>
<td>USCDC** (2)</td>
</tr>
<tr>
<td></td>
<td>Australian Embassy (1)</td>
</tr>
<tr>
<td>International NGOs</td>
<td>1</td>
</tr>
<tr>
<td>Research institute</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
</tr>
</tbody>
</table>

Notes: *MOH: Ministry of Health; **CDC: Centers for Disease Control and Prevention in China’s Department of Health and Human Services.
3. Development of International Health Cooperation

History, Current Trends and Future

History

Cooperation between countries on health issues has a long history. According to Banta, the pandemic of the bubonic plague in the fourteenth century can be cited as the beginning of international action on health. The plague forced countries to engage in a diplomatic dialogue and make agreements to protect their public health and contain the pandemic of infectious disease. For several centuries, as ocean shipping and travel continued to be the major vehicle for spreading infectious diseases and epidemics, the policy of quarantine was an effective means for controlling the spread of infection.

By the middle of the nineteenth century, aiming to reconcile international commerce and public health, a series of international sanitary conferences was convened. The first conference in Paris on 5 August 1851 was attended by government representatives of 12 countries. The subsequent sequence of events provided the first of many examples of the difficulties in agreeing on action for international health. In 1907 the Office International d’Hygiène Publique was established in Rome with the principal function to gather and share epidemiological information. Although most of these conferences were ad hoc and largely limited to epidemic intelligence gathering between scientists or professionals, they led to international agreements on common approaches for the control and treatment of disease.

After World War II ended in 1945, a truly international health establishment came into being with the founding of the World Health Organisation, which was internationally ratified in 1948. The inception of a new era for international health cooperation was identified with enunciation by Harry S. Truman, in his 1949 inaugural address as US President, that the United States embark on a program of foreign aid and technical assistance for improvement and socioeconomic development of the underdeveloped world, a program which included health programs. Still today, many others have joined the task of providing aid and technical assistance to the developing world, such as the Australian Agency for International Development (AusAID), the UK Department for International Development (DFID), and the Swedish International Development Cooperation Agency (SIDA).

Current trends

The final quarter of the twentieth century saw a profound change in international health cooperation. Since the 1980s, economic growth has faltered, international insecurity has grown, and official development aid has fallen. The situation has changed from vertically organised formal institutions to horizontally linked coalitions. From being a merely bilateral effort together with a few multilateral organisations and many NGOs, new global partnerships have entered the scene and become major funding agencies. The provision of aid has also changed from a small-scale project basis to financial support of large programs.

Today the multifaceted nature of health and the multisectoral interactions that influence it have induced an increasing number of organisations to become active in the health field. Broad-ranging partnerships are increasingly being set up to target specific health problems. For example, to achieve polio eradication a global partnership was formed with, among others, ministries of health in polio-endemic countries, Rotary International,
United Nations Children’s Fund (UNICEF), the governments of Australia, Canada, Denmark, Japan, the United Kingdom and the United States, as well as NGOs.12

Future

International health cooperation in the future depends on a better appreciation of the meaning of modernisation, as interpreted by each country, and recognition that modernisation itself is a complexity of many factors.13 Chen, Evans and Cash pointed out that future international health cooperation will be influenced by at least three factors – resource mobilisation (as public expenditures to promote global health are strong on economic, moral and practical grounds), systems of global governance (gaps and challenges may not be fatal if the systems are adaptive, flexible and responsive to changing demands), and the creation of institutional space for organisational renovation and innovation (the interactions between diverse international health agencies are conflictual and harmonious, they need to change the times and reshape their institutional instruments to meet the new challenges).14

Walt presents a pessimistic and an optimistic view for international cooperation in health in the future.15 The pessimistic vision is that multilateralism will have diminished and unilateralism increased. The UN will have focused on coordination only in wars, conflicts and natural disasters. Most of its agencies will have disappeared, and many of its policy functions will have been overtaken by global partnerships or other agencies, which will convene expert panels and develop international norms and standards.16 The optimistic view is that multilateralism will still be a force, but the UN will be smaller. NGOs will be actively involved in policy discourse and in dispensing and delivering aid. There will be no bilateral aid government–to-government. All aid will be channelled through public–private partnerships, which have the potential to draw on the comparative strengths of different institutional players.17 In this optimistic scenario, countries will still have to demonstrate good governance to receive assistance. Those countries with weak or failed governments will receive much lower levels of aid, channelled through NGOs.

Important Factors Influencing International Health Cooperation

Globalisation and international health cooperation

The process of globalisation is now advancing rapidly and broadly and leads to growing interdependence between different people, regions and countries. Globalisation has a complex influence on health, bringing benefits and risks.

Globalisation offers great opportunities for international health cooperation. The process of globalisation improves technological development and increases global interconnections. The new technologies, particularly information and telecommunication technologies, are relevant to globalisation.18 They have cut the distance between people in different parts of the world, and have facilitated inexpensive and prompt communication and massive diffusion of information.19 Improvement in communication and informational technologies has enabled international responses to catastrophic events that threaten health to be organised more rapidly and has facilitated the coordination of emergency situations. Additionally, frequent movements of people via travel and tourism have also increased interconnections. Thus, as Hurrell mentioned, globalisation has dismantled barriers and generated interconnections between states and societies to bring about greater sharing of information and increasing international interactions and collaboration.20

Globalisation requires increasing cooperation among countries to ensure the stability and security of the global system, a reason why implementation of international agreements has become important. For instance, industrial development creates new environmental threats, such as water and air pollution, that can transcend boundaries and impact on all human society in the global village. These issues have raised the need for international cooperation and global agreements. In today’s more interdependent world, international
cooperation, which involves the interaction of countries, international organisations and non-government actors, shapes values, policies and rules.21

As globalisation widens the gap between rich and poor nations, the interest in foreign assistance has grown in importance. Countries that lack the most basic foundations of development and requisite national development management capacities cannot effectively share the provision of global public goods, e.g., for infectious disease control or alleviation of poverty and its negative consequences.22 In a world of interconnected threats and opportunities, international aid is one of the most effective weapons. It is an investment in shared prosperity, collective security and a common future.23

In short, the widespread influence of globalisation has increased the need for international cooperation to address emerging opportunities for and threats to global health and this improves the health status of poor states that have not benefited from globalisation. As a consequence of globalisation, national governments should turn increasingly to international cooperation to attain national public health objectives and achieve some control over the trans-boundary forces that affect their populations.

Millennium development goals and global health inequality

The targets of the Millennium Development Goals (MDGs) provide a focal point for international concern, putting development and the fight against poverty on the international agenda.24 Doubtlessly that there is massive inequality among the world's people in opportunities to live a free, healthy and fulfilled life. Where systematic differences in health are judged to be avoidable by reasonable action, they are, quite simply, unfair, and are labelled as health inequity.25 Achieving the MDGs and closing the health gap between the developed and developing countries require international communities from both rich and poor countries and all partners to be involved.

The MDGs, adopted at the Millennium Summit of the United Nations in September 2000, called for a dramatic reduction in poverty and marked improvements in the health of the poor (Box 1). Three of the MDG targets relate directly to health: MDG 4 on reducing child mortality, MDG 5 on improving maternal health and MDG 6 on combating HIV/AIDS, malaria and other diseases. Health is also an important component of all the other MDG targets. The disease burden can be lessened in line with the MDGs only if there is a concerted, global strategy of increasing access of the world’s poor to essential health services.26 Achieving the MDGs will depend primarily on national efforts, but the less developed countries in particular should be able to rely on support from international communities and richer countries.

The UNDP Human Development Report 2005 stated that the gap between developed and developing countries in levels of health was widening. If current trends continue, there will be large gaps between MDG targets and outcomes. Reducing inequality in health is a public priority. It is also instrumental in accelerating progress towards the MDGs.

There is a disparity in health between rich and poor countries. Children have dramatically different life chances depending on where they are born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 73 years; India, 64 years; and in one of several African countries, fewer than 50 years.27 Deaths associated with diarrhoea and respiratory infection are rare in developed countries but are the major killers of children in developing countries; diseases that do not occur in developed countries, e.g., malaria and schistosomiasis, or ones that are comparatively rare in these countries, e.g., tuberculosis and HIV/AIDS, impose a heavy burden on both adults and children in developing countries. In the 2005 estimate, the maternal mortality ratio per 100,000 live births was nine in developed countries, 450 in developing counties and 900 in sub-Saharan Africa.28 This means that 99 per cent of the women who died in pregnancy and childbirth were from developing countries.
Box 1: The Millennium Development Goals

In September 2000, building upon a decade of major United Nations conferences and summits, world leaders came together at United Nations Headquarters in New York to adopt the United Nations Millennium Declaration, committing their nations to a new global partnership to reduce extreme poverty and setting out a series of time-bound targets – with a deadline of 2015 – that have become known as the Millennium Development Goals. These goals provide tangible benchmarks for measuring progress in eight areas.

Goal 1 Eradicate extreme hunger and poverty. Halving the proportion of people living on less than $1 a day by halving malnutrition.

Goal 2 Achieve universal primary education. Ensuring that all children are able to complete primary education.


Goal 4 Reduce child mortality. Cutting the under-five death rate by two-thirds.

Goal 5 Improve maternal health. Reducing the maternal mortality rate by three-quarters.

Goal 6 Combat HIV/AIDS, malaria and other diseases. Halting and beginning to reverse HIV/AIDS and other diseases.

Goal 7 Ensure environmental stability. Cutting by half the proportion of people without sustainable access to safe drinking water and sanitation.

Goal 8 Develop a global partnership for development. Reforming aid and trade with special treatment for the poorest countries.


Both developed and developing countries have the responsibility of facing challenges to achieve the MDGs and health inequality. Success in achieving the MDGs will require a seriousness of purpose, a political resolve, and an adequate flow of resources from high-income to low-income countries on a sustained and well-targeted basis.²⁹

Foreign policy

Historically, public health has been predominantly a domestic policy concern.³⁰ However, globalisation and developments over the last decade have forced public health experts and diplomats to think of health as foreign policy, namely public health as important to states’ pursuit of their interests and values in international relations.³¹ The advantages of using health as an instrument of foreign policy include protecting nations against health threats, building social cohesion, strengthening national infrastructure, improving bilateral relations, and encouraging trust across global multilateral agencies.³² Protecting the safety and well-being of citizens is a central security concern for governments. Ideas about human security are pushing further cooperation in public health.

Global public health security

In our increasingly interconnected and mobile world, the concern of global public health security is increased. Global public health security is defined by International Health Regulations (IHR)³³ as the activities required, both proactive and reactive, to minimise vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries. Diseases now spread geographically much faster, and they appear to be emerging more quickly than ever before.³⁴ The sudden emergence in 2003 of SARS was a vivid example of how
an infectious disease can pose a serious threat to global public health security, the livelihood of populations, the functioning of health systems and the stability and growth of economies. The lack of global health security may have an impact on economic or political stability, trade, tourism, access to goods and services and, if it occurs repeatedly, on demographic stability.35

Threats to public health security are universal. They include epidemics of infectious diseases, natural disasters, chemical emergencies or certain other acute health events. No single country – however capable, wealthy or technologically advanced – can alone prevent, detect and respond to all public health threats. Strengthening public health security requires stepped-up international cooperation, especially in those countries that lack resources, have weak health infrastructure, or are particularly vulnerable.36

In order to strengthen collaboration on a global scale, the new IHR was adopted in May 2005 by the World Health Assembly. Although all 193 WHO member states have agreed to the IHR in principle, there are many challenges to overcome. These include, for example, technical barriers (most industrialised and middle-income countries have the core capacity to meet the surveillance, diagnostic, and containment demands of the IHR, but many developing countries do not); financial barriers (the IHR 2005 obliges WHO and member states to collaborate in mobilising financial resources to improve their core capacity but the regulations do not include any concrete financing mechanisms); and political barriers (for the IHR to work, no territory can be excluded from the global surveillance system, especially in light of the threat posed by avian influenza).37 Overcoming the barriers effectively and in time implementing IHR require global partnerships that bring together all countries and stakeholders in all relevant sectors, to gather the best technical support and mobilise the necessary resources.38

Benefits for Developing and Developed Countries

Benefits for developing countries

Development aid aims to build and strengthen capacity in developing countries through technical assistance and grants or loans can be of crucial importance. Developing countries face enormous health problems, notably from infectious diseases such as HIV/AIDS, malaria and tuberculosis, and lack of access to basic health care, clean water, adequate sanitation and food. Because of their limited resources, implementing effective measures to control disease in most developing countries requires external assistance. Improving international cooperation, as Kaul et al. have argued, can strengthen the capacity of national governments to achieve their national policy objectives.39

Benefits for developed countries

Becoming involved in international health projects is also beneficial for the developed countries. Developed countries can play a vital part in helping solve global health problems, and it is in their own interests as well as those of developing countries to do so.40 The importance of international engagement in a globalised world has been emphasised in many developed countries. The American Institute of Medicine in its 1997 report ‘America’s Vital Interest in Global Health’ argues three key interests of extensive American engagement in world health: protecting America’s population, enhancing the American economy, and advancing America’s international interests.41 The report notes that in partnership with other countries and international organisations, the United States can lend a great deal in the areas of research and development, surveillance, education and training, and coordination and leadership.42 Rekart et al. have presented five reasons why Canada should become involved in international health projects (Box 2).43
Box 2: Five Reasons Why Canadians Should Become Involved in International Health Projects

1. Global health affects the health of Canadians. Canadians cannot safeguard their health by closing borders or ignoring the health concerns of those less fortunate.

2. Global health affects the security of Canadians. Canadians can contribute to improved global security by helping poor nations focus on the major avoidable causes of death and disability: HIV/AIDS, malaria, TB, childhood infections, maternal and prenatal conditions, micro-nutrient deficiencies and tobacco-related illness.

3. International projects give Canadians opportunities to make new discoveries, use their knowledge in new ways, and gain experience with interventions and diseases currently uncommon in Canada.

4. Successful international projects enhance Canadian credibility and promote excellence for Canadian agencies and individuals.

5. Empowering people in developing countries to deal more effectively with their problems can generate personal satisfaction for individual Canadians.

Four Main Players in International Health Cooperation

Multilateral organisations

Multilateral organisations are organisations whose members include at least three countries, that have activities in several countries, and whose members are held together by a formal intergovernmental agreement. Multilateral organisations include United Nations agencies, multilateral development banks (e.g., the World Bank and regional development banks), and regional groupings (e.g., certain European Community and Arab agencies). Within the UN agencies, the leading role of the WHO in international health is unquestioned; the World Bank also makes major contributions, especially after the publication of its landmark 1993 World Development Report, Investing in Health. Other UN agencies have also become more influential, including the United Nations Children’s Fund (UNICEF), the United Nations Development Program (UNDP) and the United Nations Population Fund (UNPF). Moreover, some bodies such as the World Trade Organisation (WTO) may not have participated in the development of health initially but now are seen as important players with regard to many of the tradable determinants of health. For others, such as the Organisation for Economic Cooperation and Development (OECD) and the Regional Development Bank, health may be a side issue but their overall importance on the international scene makes them significant players.

There is no doubt that multilateral agencies play a vital role in international health cooperation, but there are many issues of concern. With many sovereign member states, the focus of much of their work is communication. For example, within the UN agencies, discussions are conducted in many languages and documentation is available in six official languages. Thus it is not surprising that progress is slow and painstaking. Multilateral organisations include many different bodies, agencies and programs. Balancing power within these bodies and sharing financial responsibility for their work are continuing challenges. Other issues such as lack of sufficient authority and resources to implement its policies and plans effectively, lack of coordination, poor leadership, petty (and sometimes not so petty) corruption, bureaucratic tangles, and waste of resources have also been evident.

National development agencies (bilateral agencies)

National development agencies (bilateral agencies) are government agencies in a single country, which provide aid to developing countries. Most of them are members of the Development Assistance Committee (DAC), the organisations from the OECD. For them, health may be a side issue, but their overall importance on the international scene...
makes them significant players.\textsuperscript{53} The DAC member countries and the names of their aid agencies are listed in Table 2.

Table 2: DAC Member Countries and Their Aid Agencies

<table>
<thead>
<tr>
<th>Country</th>
<th>Government Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Australian Agency for International Development (AusAID)</td>
</tr>
<tr>
<td>Austria</td>
<td>Austrian Development Agency (ADA)</td>
</tr>
<tr>
<td>Belgium</td>
<td>Development Cooperation (DGDC)</td>
</tr>
<tr>
<td></td>
<td>Technical Cooperation (BTC)</td>
</tr>
<tr>
<td>Canada</td>
<td>Canadian International Development Agency (CIDA)</td>
</tr>
<tr>
<td>Denmark</td>
<td>Danish Ministry of Foreign Affairs</td>
</tr>
<tr>
<td>Finland</td>
<td>Ministry of Foreign Affairs</td>
</tr>
<tr>
<td>France</td>
<td>Ministry of Foreign Affairs</td>
</tr>
<tr>
<td></td>
<td>Le Groupe de l'Agence française de Développement (AfD)</td>
</tr>
<tr>
<td>Germany</td>
<td>Ministry for Economic Cooperation and Development</td>
</tr>
<tr>
<td></td>
<td>(Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung, BMZ)</td>
</tr>
<tr>
<td></td>
<td>Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)</td>
</tr>
<tr>
<td></td>
<td>Development Cooperation (KfW)</td>
</tr>
<tr>
<td>Greece</td>
<td>Ministry of Foreign Affairs</td>
</tr>
<tr>
<td>Ireland</td>
<td>Irish Aid</td>
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<td>Italy</td>
<td>Ministry of Foreign Affairs</td>
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<tr>
<td>Japan</td>
<td>Ministry of Foreign Affairs</td>
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<td></td>
<td>Japan International Cooperation Agency (JICA)</td>
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<td></td>
<td>Japan Bank for International Cooperation (JBIC)</td>
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<td>Luxembourg</td>
<td>Ministry of Foreign Affairs</td>
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<td>Portuguese Institute for Development Support (IPAD)</td>
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<td>Spain</td>
<td>Spanish Agency for International Cooperation (AECI)</td>
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<td>Sweden</td>
<td>Swedish International Development Authority (SIDA)</td>
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<td>Switzerland</td>
<td>Swiss Agency for Development and Cooperation (SDC)</td>
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<td></td>
<td>State Secretariat for Economic Affairs (SECO)</td>
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<td>United Kingdom</td>
<td>Department for International Development (DFID)</td>
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<tr>
<td>United States</td>
<td>United States Agency for International Development (USAID)</td>
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<tr>
<td></td>
<td>Millennium Challenge Corporation (MCC)</td>
</tr>
</tbody>
</table>

Source: OECD, Development Co-operation Directorate
www.oecd.org/dac/memberswebsites

The practice of international development aid has moved away from the traditional donor–recipient model to more multilateral, cooperative models.\textsuperscript{54} Donor government allocations to development assistance for health (DAH) are channelled in a variety of ways: directly to partner governments; through the UN system; through NGOs working at country, regional, and global levels; and through various global initiatives involving several stakeholders.\textsuperscript{55}
With the rapid increase in flows of development assistance to health, national development agencies face many challenges. One of the problems is that the budget targets set by donors may not be achieved. Many donors find their geographic and sector aid allocations frequently driven by domestic political leadership or legislative initiatives. Even where donors establish clear allocation priorities, it may be difficult to convince domestic decision makers of the importance of maintaining such a disciplined and longer-term approach. Another issue of bilateral aid is that it lacks transparency. Commitments are funds that are set aside to cover costs for a project that most often spans several years. Disbursements are funds actually expended. Most agencies routinely report commitments made each year, but only a few report disbursement.

**Non-government organisations (NGOs)**

The non-government organisations, or NGOs, are largely a post-World War II phenomenon. They are private, voluntary organisations whose members are individuals or associations that come together to achieve a common purpose. The World Bank defines an NGO as a group or an institution that is entirely or largely independent of government, and which has primarily humanitarian or cooperative rather than commercial objectives. At national level, NGOs are often called interest or pressure groups, and many of them are now linked to counterpart groups in other countries through transnational networks or federations. International NGOs may draw their numbers from one region or several regions, and they may have very specific functions or be multifunctional.

The increasing role of the NGOs in the international field has been enhanced by expectations of greater effectiveness in health cooperation. The process of increased channelling of funds through NGOs, however, is also reflected in the work and structure of NGOs. International support is often project-specific, which causes NGOs difficulties with organisational costs; it is usually available only for limited periods, and international donors are often interested only in supporting capital or start-up costs. Uncertain funding sources contribute to shaky NGO projects that are of short duration, locally disruptive and often unsustainable. The achievements of short-term projects can evaporate when NGOs leave due to inadequate training or a lack of resources in local health institutions. Moreover, as Koivusalo and Ollial argued, increasing funding possibilities may also create private interests to be channelled into nongovernmental action where lines between for-profit firms and non-profit organisations may be blurring, or private interests in terms of income or social status may lead to increasing hollowness of non-profit claims from NGOs.

**Public–private partnerships (PPPs)**

As we move into the 21st century, Public–Private Partnerships (PPPs) are becoming a popular mode of tackling large, complicated and expensive public health problems. Many kinds of public–private partnerships for health have emerged in recent years. They play a significant role in cross-border initiatives. Partnerships between public and private organisations offer a good chance of producing the desired outcomes. But these partnerships also bring their own problems such as conflicts, issues of representation, accountability and transparency. Future research is needed to address these problems.

PPP describes a government service or private business venture that is funded and operated through a partnership of government and one or more private sector companies. It is an alliance of partners from UN agencies, developing countries, donor governments, foundations, corporations and NGOs. Reich identified three characteristics of a PPP: it involves at least one private for-profit organisation and at least one not-for-profit or public organisation; the partnerships have some shared objective for the creation of social value, often for a disadvantaged population; and the core partners agree to share both the efforts and the benefits. The objectives of PPPs are listed in Box 3.
Box 3: Objectives of Public–Private Partnerships

- Developing a product, e.g., the Medicines for Malaria Venture and the International AIDS Vaccine Initiative.
- Distributing a donated or subsidised product, to control a specific disease, e.g., initiatives to distribute leprosy medicines. Concerns have been expressed about these initiatives as not tackling the health problems of highest priority, as perceived locally.
- Strengthening health services, e.g., the Gates Foundation/Merck Botswana Comprehensive HIV/AIDS partnerships.
- Education the public.
- Improving product quality or regulation.


Many kinds of public–private partnerships for health have emerged in recent years. Public–private partnerships and funds have been established for programs such as Roll Back Malaria; the Global Polio Eradication Initiative; the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); the Global Alliance for Vaccines and Immunisation (GAVI) and Stop TB. Partnerships have become fashionable with every major disease, which seems to have its own global alliance or partnership. Some global health partnerships with their focus on a country–driven approach, accountability and results – notably GAVI and the GFATM – have shown that in poor countries substantial finance can be absorbed and better health can be delivered.

Public–private partnerships are at the top of many agendas in international public health these days. They are seen as an innovative method with a good chance of producing the desired outcomes. But these partnerships also bring their own problems.

First, many different kinds of organisations are joining public–private partnerships, and they bring with them different cultures, governance structures and financial resources. These differences create challenges in the partners’ efforts to collaborate effectively and achieve their objectives. Also, differences in public and private ethos may create tensions or conflicts of interest for those involved. For example, sharing information may be difficult: private industry or researcher groups may want to protect product leads or early data from trials. There may be debates on risks, such as those around public to private subsidies, or on setting norms and standards, or on agreement between prices and profitability.

Second, the governance issues are in the realm of representation, accountability and transparency. The representation issue raises question of whose interests should be represented in the partnership and whose should not. The universality of multilateral institutions is diluted by partnerships, since some partners may represent a wide constituency of members while others, such as the private sector or NGOs, may not. Accountability, which is broadly concerned with being held responsible for one’s actions, may also be interpreted in different ways by different partners. Both the public and private sectors have effectively established their own mechanisms of accountability. However, accountability within public–private partnerships may be less straightforward. Furthermore, since partnerships can involve a range of partners with different rights and responsibilities, achieving the governance goal of transparency may also raise difficulties. Thus, it is important for public–private partnerships to specify what accountability means and how that accountability can be implemented and assured with adequate transparency.

Additionally, such partnerships focus on much narrower programs of disease control, which has led to monitoring themselves and neglecting other important issues in health, such as developing good quality and accessible health systems, in which outcomes and impact are more difficulty to measure. Partnerships may also raise issues around
equity, by choosing to work in some countries with a particular disease rather than all countries.80

Key Challenges and Possible Solutions in International Health Cooperation

Key challenges in international health cooperation

The first issue in international cooperation for health, identified by Walt, is overlapping mandates.81 Although each organisation has its own comparative advantage, it is not clear that in practice these always coincide or are complementary. For example, in the field of children’s vaccines and immunisation programs there are overlapping interests among several organisations: WHO, the partners of the Task Force on Child Survival, and the newly established Children’s Vaccine Program of the Melinda and Bill Gates Foundation, among others. This confusion had affected vaccine uptake and financing.82 The danger of overlapping continues today, at both global and country levels.83

Second, as there are so many different players in international health cooperation, one of the main concerns is the extent to which competition and duplication of health activities occur. Poor coordination between the donors makes them act independently. On the one hand, national governments may experience negative cumulative effects, with multiple donors making demands on officials’ time, each donor wanting its own project presentations, evaluations, accounting systems and meetings.84 On the other hand, some have claimed that governments may also use competition for attention to play donors off against each other.85

Third, the swelling numbers of players in the health sector has resulted in a proliferation of projects. This increase in projects has placed a burden on health departments and the cost of administration for the projects has risen. It has led officials in health departments to spend ‘most of their working hours entertaining visiting delegations, meeting donors, and preparing project documents’.86 The proliferation of channels of funds may also have increased the accompanying administrative costs.87 For example, the cost of channelling funds from donor governments through national agencies to the multilateral system is estimated to reduce the funds available for direct health interventions by some 17 per cent, excluding any additional overheads arising from the use of funds by the multilateral organisations.88

Finally, the policy issues are hard to manage. International cooperation is highly dependent on ownership, capacity, and transparency of the primary actors in the health sector – the Health Departments, other government agencies, and public and private providers of health care services.89 Health is a complex sector with many kinds of actors, needs and financing streams. The policy issues are especially hard to manage in the health sector because of the strong moral content of health-related concerns, and the many conceptual and ethical challenges.90

Possible solutions

Country ownership should be ensured. Humanitarian aid was found to work best when local communities and authorities had been consulted and involved in the planning and management of programs.91 All the recent cooperation initiatives in health recognise this, and emphasise stronger co-ordination, harmonisation and alignment within country-led and country-managed single health plans. Partner countries need to take the lead in determining priority programs, and international communities must respect the national priorities and development agenda of partner countries.92 Many studies have shown that aid is not aligned with government priorities, and holistic health systems’ approaches are insufficiently funded.93 Ownership also requires that countries are strongly involved in the design and implementation of these initiatives, including the selection of pilot countries, and that civil society is engaged in the discussion of cooperation in health.94 Coordination should be driven by partner countries. Some 30 to 40 years of developing cooperation have taught the international development
community that successful and sustainable development processes are founded on nationally based forces of change and willingness to progress.95

Both donors and their partner countries should fulfill their political and administrative commitments. The political environment has strongly influenced the evolution of international health cooperation.96 Past experience shows definitively that political and administrative commitments are the keys to success.97 The international donor community should commit adequate grant resources for low income countries to ensure universal coverage of essential health interventions. The countries should enforce their political commitment. All partners need to fulfill their commitments, with a focus on practical and collective action within the agreed frameworks that build on the comparative advantages of each partner.98

The partnership should be integrated. Clearly, international communities, donor governments and their agencies, and other organisations must make broader links and work more closely together. This not only simplifies the task of overstretched national administrators, it also avoids duplication and waste, and makes international support more coherent and effective.99

Donors and countries should build an effective partnership. Although international cooperation for health has worked effectively in the past, there has been considerable change. Therefore, donors and countries need to collaborate more effectively. An effective partnership of donors and recipient countries, based on mutual trust and performance, is essential.100 The partnership would need to proceed step by step. As improvements in public health and health outcomes take time (sometimes a very long time), a long term perspective is required to ensure the strength of partnerships for any new or renewed engagement.101

In short, from international health cooperation literature we see that the possible solutions mentioned above may help international communities and their partner countries to make sounder decisions in international health cooperation. Further research needs to focus on examining and testing these solutions.
4. International Health Cooperation in China

China’s International Health Cooperation Management

Department of International Cooperation, Ministry of Health

The Ministry of Health (MOH) brings together different sectors, international organisations and NGOs to manage international cooperation on health in China. The Department of International Cooperation in MOH is in charge of cooperation between the MOH and international organisations, foreign government agencies and foreign institutions. The Department is also responsible for assisting other departments to promote major international cooperative projects and carry out studies on world health and day-to-day foreign affairs of the Ministry.

According to the ‘Administrative Rules for international health cooperation projects (For Trial Implementation)’ issued by MOH, the international health cooperation program is under the centralised management of the departments of foreign affairs within the health administration department and medical institution at all levels. These departments are responsible for the administration and coordination of international cooperation programs.

China’s national guidelines on international health cooperation

‘Outline of the 11th Five-Year National Plan for the Development of Health Undertaking’ provides China’s guide for international health cooperation:

International health cooperation should adhere to the principle of supporting and servicing national health reform and nations’ international affairs. It should tighten up health cooperation with all other countries and further strengthen relations with international organisations such as the WHO and the Global Fund. Through bilateral, multilateral and non-governmental channels, it should strive actively for international cooperation programs and funding, and seek to enhance medical technology and health management. It should strengthen supervision and management of cooperative programs, and seek to increase efficiency of fund utilisation. Meanwhile, it should actively carry out foreign medical assistance, support developing countries in preventing and controlling HIV/AIDS, malaria and other infectious diseases, and help to train health workers. It should also explore new ways and new channels of foreign medical assistance and improve its effectiveness, while serving national diplomacy.

China’s MOH issued ‘Administrative Rules for International Health Cooperation Programs (For Trial Implementation)’ in 2007. The document states clearly that the principles of international health cooperation are equality and reciprocal benefits, results sharing and observance of international norms. International health cooperation programs should be in accordance with the requirements of local health development and with the overall deployment of national health development strategies.

In 2008, in accordance with ‘Administrative Rules for International Health Cooperation Programs (For Trial Implementation)’, MOH formulated another two relevant papers: ‘Financial Administrative Measures for Foreign Funded International Health Cooperation Programs’ and ‘Detailed Regulations on Management for National-level International Health Cooperation Programs’. The first paper aims to tighten control over foreign funds and improve the benefits from fund usage. The second paper addresses the whole process of management with regard to initiating and approving programs; signing
documents; using funds; implementing, auditing and overseeing projects and other matters. These three papers are the current guides for China's international health cooperation management.

**Benefits of China's International Health Cooperation**

*Overall investment in the health and development program has been increased*

China's rapid economic growth over the past two decades has not been reflected in increasing public investment in health. The government health budget as a share in China's GDP has remained quite low in the last ten years. Overseas development assistance to China provided funds that help to fill the gaps left by government investment in health and make up for insufficient funding in poor areas. Until 2008, loans from the World Bank to China's health program have totalled US$972.60 million and have been allocated to 30 provinces, autonomous regions and municipalities. In 2007, official development assistance to China's health sector from all multilateral and bilateral donors totalled US$109.1 million.

*Health outcomes in project areas have been improved*

For example, the Implementation Completion Report of the World Bank Disease Prevention Project shows that over the life of the project (1996–2004), both the infant mortality rate and the under-five mortality rate dropped in all provinces where the project was under way; the incidences of measles, pertussis, cerebrospinal meningitis, Japanese B encephalitis, and hepatitis B all declined, and immunisation coverage has been largely increased.

*Development experiences and many methods from wealthy sources have been introduced, tested and deployed*

This has played a positive role in developing theories and policy measures and in institution building for the health sector. Some concepts such as disease intervention, community health, medical insurance and DOTS (Directly Observed Treatment, Short-course) have been used widely within the country; some have already been incorporated in national health policy. For example, a result of the World Bank's Integrated Regional Health Development Project 1989–98 was successful introduction of a systematic approach to health planning. Requiring close institutional coordination by regional level health facilities in the planning, management and delivery of health services, it reduced duplication in China's multi-program health service provision and improved efficiency. The use of demographic data was enhanced, which led to better delineation of health plans and programs based on population requirements. The lessons learned from the successful project and the 'regional health planning' strategy were widely disseminated, culminating in the State Council's adoption of the strategy as a key for health sector reform.

*Project management has been improved*

Compared with domestic projects, foreign-funded programs have a longer preparation period. With specific plans and targets, capital and projects have been according to the annual plan, and implementing these projects appears to have been more efficient. Strict scientific management standards were applied to make the projects more transparent. Moreover, monitoring and assessment systems were established to ensure successful achievement of predetermined objectives. The management process has been constantly adjusted and improved in order to be replicated in various regions, and successful experiences are being applied gradually in domestic projects. Through piloting practice in project design, implementation, monitoring and management, international cooperation projects summarise and accumulate valuable experiences and models that conform to China's national conditions and therefore play a significant role in promoting management levels.
Contributions have been made to capacity building and human resource development

International health cooperative projects have improved the varying competencies and capabilities of different communities in China so these communities are better able to operationalise health programs. A large cadre of administrative, management and professional staff has been trained through international cooperation. Many personnel who gained experience from the projects have already become a staunch force in their field. Constant training is very important for building a qualified taskforce, and for improving management and institutional innovation as well.

International exchanges and cooperation in health have been promoted

International cooperation in health promotes China’s exchanges with other countries and increases friendship and mutual understanding with international communities. The Chinese government highly values the international experiences and assistance that international cooperation can bring. In a rapidly changing and populous middle-income country like China, the international experience and the technical expertise can help China to attain more equitable health outcomes. Both of these also support progress towards the achievement of global health norms and standards and the Millennium Development Goals. Similarly, China’s contributions to international public health are essential for cross-border issues such as the prevention and control of infectious diseases, food and drug safety and environmental health. In addition, China has considerable technical knowledge and an increasingly wide range of good public health experiences, lessons and practices to share with other countries.

Needs and Opportunities for International Health Cooperation in China

Needs for international health cooperation in China

China is still a lower-middle-income country facing many problems in public health, with many millions of people living on less than a dollar a day. There is still a range of public health challenges from tuberculosis to HIV/AIDS, from infectious diseases to the growing problem of non-communicable diseases. Emerging infectious diseases (such as Severe Acute Respiratory Disease Syndrome or SARS, and avian influenza) are increasingly important, as are health-related trade issues such as food safety. Inequities in access to quality health services and huge disparities in health outcomes remain. International collaboration is necessary to prevent and control infectious diseases, address environmental health issues, regulate food, product and drug safety, and address other health related issues.

While increasing public investment in health has contributed to improved health outcomes, health spending has not risen as rapidly as overall budget spending. The government health budget as a share in China’s GDP has remained quite low in the last ten years. Furthermore, the national system faces heavy constraints at the provincial and local levels. Local governments bear heavy public expenditures that are not covered by central funding, and weak financial controls sometimes impact on the flow of funds and their intended use. There are also great disparities in the distribution of health resources including health care practitioners, between China’s cities and rural areas and its coastal regions and inland regions, and this gap continues to grow. Seeking foreign capital from international financial organisations and bilateral governments for supporting health development in China is one of the government’s strategic choices.

China is ahead of schedule in achieving most of the MDGs, benefiting from the positive effects of both rapid economic growth and targeted government programs. But the ultimate achievement of the MDGs, which mainly targets child and maternal mortality, HIV/AIDS and tuberculosis, and seeks to ensure access to basic water and sanitation, is still facing challenges. It is apparent that the government alone cannot solve the problem.
The Chinese government has made global commitments to improve health. Recently, China has signed a number of important health related international agreements. The International Health Regulations or IHR and the WHO Framework Convention on Tobacco Control (FCTC) were signed respectively in 2003 and 2006. China has also ratified two other important frameworks: the Convention on the Elimination of All Forms of Discrimination Against Women in 1980 and the Convention on the Rights of the Child in 1992. As China has become an increasingly important part of global health over the past several decades, it is very important – indeed necessary – for China to strengthen international health cooperation, improve its health development, and make contributions to global health.

Government agencies continue to request international technical support and contributions to human resource development in health. The existing national human resources strategy for the health sector in China needs to be revised based on health reform plans. It also needs to address the gaps in capacity and deployment for rural and remote regions, as well as at the peripheral levels of the health system. In a vast, diverse and populous country such as China, technical assistance and the contribution of trained health professionals are still needed to achieve equitable national development and growth, as well as to help China to adopt international norms, meet global standards and contribute to critical areas for health.

Finally, China’s contributions to international public health are essential for cross-border issues such as the prevention and control of infectious diseases, food and drug safety, and environmental health. China has considerable technical knowledge and an increasingly wide range of good public health experiences, lessons and practices. It has conducted training courses for HIV professionals from African countries, cooperated in the development of pilot AIDS projects in cross-border areas of China, Myanmar, Laos and Vietnam, donated US$10 million to the Global Fund, demonstrated best practice in China through hosting delegations from countries to undertake study tours of AIDS interventions in China, and actively participated in sharing information at international conferences. It is therefore necessary to strengthen China’s role in international cooperation and multilateralism, so that China can contribute through sharing what it has with other countries.

Opportunities for international health cooperation in China

Achieving international health cooperation requires immense political resolve. The current political environment and commitment to addressing health concerns have created unprecedented opportunities for international health cooperation. It will still be one of the strategic choices of the government in the foreseeable future.

Since 2003, the Chinese government has shown commitment to public goods in health and has expanded its investment in health. In the aftermath of the SARS epidemic, public health has been placed higher on the national agenda. As a result, a national consensus has emerged that the government needs to re-assume greater responsibility for public health functions and services, including health surveillance, reporting, regulation, and prevention and control of infectious diseases.

Health is still a priority in the 12th Five Year Plan (2011–15), which reveals the Chinese government’s commitment to addressing health inequalities and public health issues. This provides a sound basis for cooperation between the Government of China and international communities.

As the world’s most populous country and a leading economic power, China has a natural place at the heart of global dialogue and cooperation, and has become a major investor in many of the poorest developing countries. For instance, China is a donor to the Global Fund to Fight AIDS, TB and Malaria and has been a board member representing the Western Pacific region since its foundation. Thus, one of the priority areas of the UN
Development Assistance Framework for 2006–10 was strengthening China's role in international cooperation and multilateralism.127

International Agencies in China

Multilateral organisations

World Health Organisation (WHO)
In 1981, the WHO set up its office in Beijing, increasingly strengthening friendly cooperative relations. In 2004, the Chinese Ministry of Health and the WHO Director-General signed a Memorandum of Understanding (MOU) to strengthen health cooperation and exchange, identifying key areas of cooperation: 1) public health priorities (rural health, prevention and treatment of major diseases and mechanisms for public health emergency responses); 2) control of major communicable diseases (HIV/AIDS, TB, hepatitis B, schistosomiasis, malaria and other emerging diseases); 3) non-communicable diseases (including health determinants such as environment, tobacco control and food safety); 4) traditional medicine (including standard setting, quality control, and safe use of TCM in accordance with World Health Assembly policies); and 5) human resources for health. During the period 2002–07, expenditures under the Program budget totalled US$61.421 million, and the country planning figure for the regular budget was US$7.08 million for the 2008–09 biennium.128

World Bank (WB)
Another important multilateral organisation in China's health sector is the World Bank. In early 1982, China submitted to the World Bank a proposal on the Rural Health and Medical Education Project. Collaboration with the World Bank in the health sector has been formally carried out since then. Up to now, the World Bank loan projects have covered 30 provinces, autonomous regions and municipalities, except Tibet, Hong Kong Special Administrative Region (SAR), Macao SAR and Taiwan province.

Other key multilateral organisations in China's health sector and the main areas of support they provide are shown in Box 4.

Bilateral agencies

Australian Embassy/Australian Agency for International Development (AusAID)
The Australian government, through its official aid agency AusAID, has provided China with development assistance for over 25 years. In 2007–08, AusAID country program aid to China totalled $30.7 million. Australian assistance through AusAID’s regional and global programs and through other government departments brought the total of ODA to an estimated AU$41.6 million.129 Health-related activities support the ongoing development of China's capacity to halt and reverse the spread of HIV, protect its population against emerging infectious diseases and strengthen its health systems. The project investment focuses on western areas of China, such as Xinjiang, Yunnan, Guangxi and Tibet.130

Canadian Embassy/Canadian International Development Agency (CIDA)
Since signing the General Agreement between Canada and China on Development Cooperation in 1983, CIDA’s China Program has evolved from having an early focus on technology transfer and broadly based training programs to being a targeted program of specialised cooperation. Canada provides official development assistance (ODA) for development cooperation with China through CIDA bilateral and partnership programs directly supporting Canadian institutions, firms and NGOs working with Chinese partners. Canada also contributes to multilateral institutions working in China, such as the Global Environment Facility and the World Health Organisation. CIDA does not have a large involvement in the health sector, where its major activities are in occupational health, reproductive health care, emerging diseases, environment health and health personnel development.131
Box 4: Key Multilateral Organisations in China’s Health Sector and Their Main Areas of Support (since 2004)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Main Areas of Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian Development Bank (ADB)</td>
<td>Nutrition, surveillance, food safety, CSR, HIV/AIDS</td>
</tr>
<tr>
<td>Food and Agriculture Organisation for the United Nations (FAO)</td>
<td>Avian influenza, food safety</td>
</tr>
<tr>
<td>International Labour Organization (ILO)</td>
<td>Occupational health and insurance</td>
</tr>
<tr>
<td>UN Foundation</td>
<td>Measles elimination</td>
</tr>
<tr>
<td>Joint United Nation Program on HIV/AIDS (UNAIDS)</td>
<td>HIV/AIDS coordination</td>
</tr>
<tr>
<td>United Nations Development Program (UNDP)</td>
<td>Environmental health</td>
</tr>
<tr>
<td>United Nations Industrial Development Organization (UNIDO)</td>
<td>Health and trade issues, food safety</td>
</tr>
</tbody>
</table>


UK Department for International Development (DFID)
DFID’s Country Assistance Plan for 2006–11 for China has two priorities: to continue to support China’s efforts to achieve the MDGs on basic education, health, HIV/AIDS, and water supply and sanitation; and to support the development of a global partnership for development. In the health sector, DFID focuses on western provinces, working on child and maternal health, HIV/AIDS and TB, improving health services and reforms to the health system. According to the UK Foreign and Commonwealth Office, DFID has committed over £55 million to HIV and AIDS work in China since 2000, £27 million to a World Bank project on TB control which covers 16 provinces, and over £31 million to strengthen China’s health system so that more poor people can benefit from basic health services. The DFID’s program in 2007/08 was valued at £33.16 million, provided entirely on grant terms.132

Japan International Cooperation Agency (JICA)
Since 1979, Japan has been the largest bilateral donor to China. Based on China’s 11th Five-Year Plan, JICA’s technical cooperation is implemented in three priority areas: cooperation towards resolving environmental and other global issues, assistance for opening and reform policy, and promotion of mutual understanding.133 In fiscal 2007, technical cooperation expenses in China were 3.708 billion Japanese yen.134 In the health sector, the cooperative areas include: polio control, expanded program on immunisation (EPI), tuberculosis control, serious infectious disease control and HIV/AIDS.135

International non-government organisations (NGOs)
International nongovernmental organisations play an important role, particularly at grassroots level. According to the China Development Brief, over 200 international NGOs are operating in China. In recent years, the number of international NGOs involved with China’s health sectors has increased, the organisations themselves have begun to mature, and key partners including the Chinese government now increasingly recognise the importance of NGO participation. More recently, a number of donors have increased funding levels for health development. The Gates Foundation has committed US$50
million for HIV/AIDS and US$25 million for TB in 2007. Save the Children also increased health resources to China.136

**International public–private partnerships**

**The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)**

The GFATM grants greatly exceed funding provided by multilateral and bilateral agencies, and play an increasingly important role in influencing the national health agenda. Since 2003, the GFATM has provided a total of almost US$313 million in grants to China.137 GFATM funding for HIV/AIDS has helped to support HIV treatment, care and prevention, reduce transmission, and mobilise civil society to scale up HIV/AIDS efforts. GFATM assistance for TB control has focused on expanding DOTS, improving health promotion, capacity building and addressing major threats to TB control (e.g., drug resistant TB, TB in internal migrants, TB/HIV co-infection). GFATM efforts to control malaria focus on addressing high transmission regions and rolling back re-emerging malaria.

**Global Alliance for Vaccines and Immunisation (GAVI)**

GAVI is a global health partnership launched in 2000 and is dedicated to saving children's lives and protecting people's health through increased access to vaccines and improved health systems. Since 2002, GAVI has supported expansion of Hepatitis B immunisation to reach all Chinese newborn infants, providing US$38 million of co-funding for the US$76 million China GAVI project on Hepatitis B vaccination and immunisation injection safety.138 The Alliance comprises partners including UNICEF, WHO, the Gates Foundation, the World Bank, developing country governments, donor country governments, the vaccine industry, civil society groups, and research and technical health institutes.139

There are many other public–private partnerships such as the China Health Alliance, which addresses TB and AIDS in China, and is active in the health sector.

**Major Challenges of International Health Cooperation in China**

International aid to China is declining. With China's graduation from a low-income country to a lower-middle-income country, and its own expanding overseas aid programs, ODA flows to China are anticipated to decrease. Major donors, such as the UK’s DFID and Japan’s JICA, have already scaled back operations and plan to cease or decrease funding significantly through 2013.140 While these decreases in aid are being offset somewhat by increases from other aid agencies and possibilities for private sector resource mobilisation, a general trend toward declining levels of aid is anticipated.141

However, in a vast, diverse and populous country such as China, international cooperation and technical assistance is still needed. With respect to declining ODA levels, it will be necessary to support the development of appropriate exit strategies in health areas where donors will discontinue external funding to ensure continuity and sustainability of program impacts.142

There are many other ministries or agencies with health related responsibilities in China, but the communication and collaboration between them is weak. The implementation of China's health policies relies on the MOH and its counterparts at lower levels, but it also needs to be involved with other departments. For the present, however, there is neither a clear allocation of responsibilities, power and resources in some key sectors, nor a system of accountability for implementing international health cooperation programs. While the MOH remains the primary focal point of international health cooperation, several key areas of work are the responsibility of other ministries or require a coordinated effort by several ministries. The limited communication between agencies results in poor implementation of programs.143 In a modern China, it is recognised that collaboration beyond the health sector is necessary to address complex public health issues.144
In addition to poor communication between Chinese health authorities, cooperation among international donors is also limited. This is because donors and the Chinese government have not put a priority on donor coordination and harmonisation of their programs. Cooperation among donors is limited, partly due to lack of the usual coordination mechanisms and to the donors’ limited interest in concrete coordination. Different cooperation modalities constitute a technical barrier. In order to improve efficiency and to avoid duplication and waste, the efforts of the various actors in international health cooperation should be coordinated and exchange of information between them needs to be improved.

China is an unusual recipient country because it is itself a large donor that has been giving and providing aid for decades to a large number of countries. The development of China’s role as a donor, boosted by the African Summit in 2006, has gradually added other components to the donors’ agenda for cooperation with China. Several multilateral and bilateral donors have made efforts to cooperate with China on development cooperation with Africa. The World Bank currently classifies China as a middle-income country. Therefore, how to develop cooperation and stress transparency, governance, ownership and sustainability are important considerations for donor communities.


Figure 1: Official Development Assistance for Health in China
5. Conclusion

International cooperation on health plays a crucial role in our globalised and independent world. In an increasingly interconnected world, such collaboration is more vital than ever, and it will still be one of the strategic choices of all national governments in the foreseeable future. Development cooperation in health is rapidly changing. In light of the many and rapid changes in the world, as well as in China, review and analysis of international cooperation are timely and necessary. This paper has aimed to improve understanding of international health cooperation and its situation in China, to identify its challenges, and offer some possible solutions so that it can be better addressed in the future.

This paper has presented an assessment of the global situation of international health cooperation and examined international health cooperation in China. It has explored the development, history and trends, needs, achievements and challenges, and suggested possible solutions to problems with international cooperation on health from global and Chinese perspectives. It can serve as a common platform for discussing the current situation and possible new directions for international health cooperation globally and in China. Specifically, for the international community, this paper can help to identify specific areas where implementation of shared health goals and capacity building in programs can be supported. For the Chinese ministries and other institutions involved in health policy and research, it is expected they will form the foundation for developing specific policy actions in cooperation with their international partners.

China is now facing an altered international environment, with the economy and health system continuing to evolve at a rapid pace. There is thus a need for considerable relevant analysis in China. To move ahead, further analysis can accompany learning. The strategic options for international cooperation on health need testing. A case study of the international health projects involving many kinds of players is proposed as the next step. Other influencing factors such as the political system, cultural factors and strategies for harmony and effectiveness will be examined in the case study. Overall, exploration of how international cooperation can best serve the needs of global health and health in China in the 21st century has just begun.
Notes

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