D1 | MONEY TALKS AT THE WORLD HEALTH ORGANIZATION

The World Health Organization (WHO) elected Tedros Adhanom Ghebreyesus as the new director-general at the World Health Assembly (WHA) in May 2017, marking the completion of two four-year terms of the current director-general, Margaret Chan.

The new director-general of the WHO inherits an organization beset with fundamental challenges that threaten the very foundations and founding principles of the organization. The WHO's capacity to intervene on issues related to international health and accomplish its basic norm-setting function has been seriously eroded over the years. The legitimacy of the WHO in affairs related to international health stands compromised. The organization's perceived failure to play a more decisive role in containing the Ebola epidemic in 2014 was met with widespread criticism (Kamradt-Scott, 2016, pp. 401–18). Underpinning the deficiencies in the WHO is its funding crisis, which does not allow the organization to carry out its normative activities. Previous editions of the *Global Health Watch* have referred to WHO's funding crisis. In this chapter, we analyse the roots and consequences of this crisis.

Image D1.1 The WHO Logo. WHO finds it difficult to effectively implement its norm setting activities (Thomas Schwarz)

Who finances WHO

For the last three decades at least, and increasingly, the WHO is burdened with a chronic funding crisis that has jeopardized its mandate and its ability to carry out all of its responsibilities with regard to global public health. The WHO's budget has always been fairly modest, increasing from approximately US$ 900 million in 1998 to about US$ 2,200 million in 2017 (Figure D1.1). The current annual budget of US$ 2,200 million is around 30 per cent of the annual budget of the US Centre for Disease Control (CDC); 4 per cent of Pfizer's turnover; 3 per cent of Unilever's turnover; and around 10 per cent of the annual advertising expenses of pharmaceutical corporations in the USA (WHA Today, 2017).

The WHO's budget is financed through a mix of assessed and voluntary contributions. As with other United Nations (UN) specialized agencies, assessed contributions are required 'membership' contributions to the budget of the WHO from member states, according to a formula based on the size of their economies and populations (Legge, 2011, p.23). Table D1.1 provides details regarding assessed contributions payable by the top 25 (in terms of their contribution) member states as assessed contributions to the WHO's general budget.

As Table D1.1 shows, the assessed contribution that countries are required to make in lieu of their membership in the WHO is extremely low. The gap is made up by voluntary contributions. Such contributions, in the form of either donations or grants, can come from public and private sources, or a blend thereof; they can vary substantially from year to year and lack the predictability needed for early warning disease preparedness and response, on-going standard-setting or capacity-building support.

In the early period after the WHO's formation, assessed contributions constituted the principal source of its budget. In 1971 of the US$ 100 million

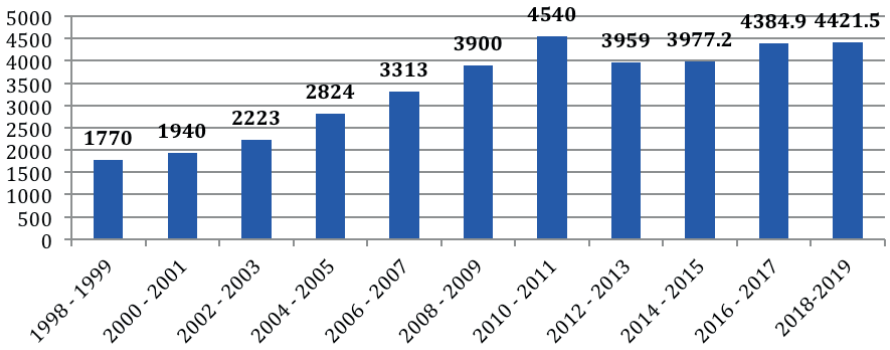

Figure D1.1: WHO biennial budget – 1998–2019 (in US$ million)

Source: Calculated from data for different years available at WHO's budget portal: http://open.who.int/

TABLE D1.1: Assessed contributions by top 25 member states

Country	Per cent of total assessed contributions	Amount of assessed contribution (in US$ million)
USA	22	115.4
Japan	9.7	50.8
China	7.9	41.5
Germany	6.4	33.5
France	4.9	25.5
UK	4.5	23.4
Brazil	3.8	20.1
Italy	3.7	19.7
Russian Federation	3.1	16.2
Canada	2.9	15.3
Spain	2.4	12.8
Australia	2.3	12.3
Republic of Korea	2	10.7
Netherlands	1.5	7.8
Mexico	1.4	7.5
Saudi Arabia	1.1	6.0
Switzerland	1.1	6.0
Turkey	1	5.3
Sweden	1	5.0
Argentine	0.9	4.7
Belgium	0.9	4.6
Norway	0.8	4.5
Poland	0.8	4.4
India	0.7	3.9
Austria	0.7	3.8

Source: Revised assessed contributions payable by member states and associate members 2017(n.d.)

budget, US$ 75 million came from assessed contribution; of the rest, three-quarters was provided by other UN agencies such as the United Nations Development Programme (UNDP) and United Nations Population Fund (UNFPA). By 1986–1987 (biennium), assessed contributions amounted to US4 543 million, matched by other contributions amounting to US$ 437 million. In 1988–1989, for the first time in the WHO's history, extra-budgetary resources exceeded assessed contributions and since then the former has progressively become the dominant source of the WHO's finances (Beigbeder et al., p. 165).

It is important to recall the chain of events that led to the WHO's increasing reliance on extra-budgetary resources. In 1980 the WHA voted to freeze assessed contributions from members in real dollar terms (subject only to currency fluctuations against the dollar) and this took effect with the 1982–1983 budget. This freeze on assessed contributions was applied across the UN system under pressure from donors led by the USA. In 1993 the WHA voted to further freeze assessed contributions by moving from zero real growth to zero nominal growth, removing the possibility of increasing the same based

on currency fluctuations and inflation. In the early 2000s the UN General assembly voted to increase UN membership dues but the WHA continued to recommend a freeze on membership dues. Not only were assessed contributions frozen but through the 1980s and 1990s many members failed to pay the assessed membership dues. Thus, for example, in 1989 the WHO was able to collect just 70 per cent of assessed contributions from member states. The largest proportion of funds thus withheld was accounted for by the USA's refusal to pay its dues (Clinton and Sridhar 2017a, pp. 90–91). In 1985 the USA paid only 20 per cent of its assessed contribution to all UN agencies. This move by the USA was interpreted in many quarters as being related to its unhappiness regarding the formulation of the WHO's list of essential medicines, in sync with the opposition to the WHO's work on essential medicines by US pharmaceutical companies (Brown and Cueto, 2010, p. 22; Clinton and Sridhar, 2017b, p. 2). The then WHO director-general, Halfdan Mahler, called this practice 'financial hostage' (Clinton and Sridhar, 2017a, p. 91).

The original intent of the constitutions of specialized UN agencies (such as the WHO) was that approved budgets would be funded through assessed member contributions. Thus a 2007 report of the Joint Inspection Unit of the UN noted that "Notwithstanding the provision for some voluntary funding, the Inspectors believe that, for the most part, the intention in the constitutions was for approved budgets to be funded through assessed contributions of the

Image D1.2 National flags in front of the UN building in Geneva. WHO is increasingly captive to demands of donors (Thomas Schwarz)

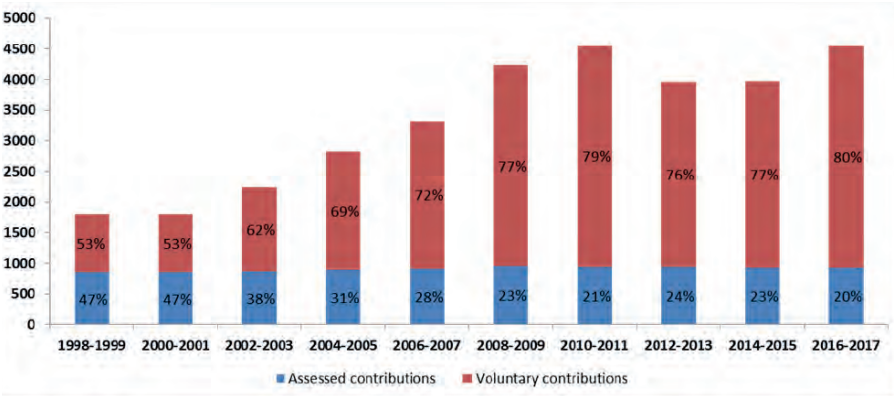

Figure D1.2: Trends in assessed and voluntary contributions, 1998–2017 (in US$ million)

Source: WHO's Financing Dialogue 2016 A proposal for increasing the assessed contribution, http://www.who.int/about/finances-accountability/funding/financing-dialogue/assessed-contribution.pdf?ua=1

Member States" (Yussuf, Larrabure and Terzi, 2007). However, the funding crisis that was precipitated in the 1980s forced UN agencies like the WHO to increasingly rely on voluntary funding from donors – countries, private foundations, other UN agencies and so on. While this succeeded in increasing overall revenue, it enormously increased the relative importance of voluntary contributions, which now make up about 80 per cent of the WHO's total budget (see Figure D1.2).

Voluntary contributions come from member states (in addition to their assessed contribution) or from other donors. These contributions can range from flexible to highly earmarked, that is, tied to a particular programme. Core voluntary contributions are funds provided to the WHO that are fully flexible at the level of the programme budget, or highly flexible at the category level, that is, only tied to a particular category of WHO's programme Core voluntary contributions allow flexibility and less well-funded activities benefit from a better flow of resources and ease implementation bottlenecks that arise when immediate financing is lacking. However, just 7 per cent of all voluntary contributions for the 2014–2015 biennium had been made to the Core Voluntary Contributions Account (WHO, 2016c). Of the total budget of approximately US$ 2.3billion in 2015, assessed contributions accounted for less than a quarter (US$ 463 million). Core voluntary contribution accounted for a meager US$ 116 million and was contributed to by just ten countries (the largest donors were the UK, Sweden and Australia). The remaining US$ 1.7 billion of the budget was contributed to by countries, other UN agencies, partnerships (like the Global Fund to Fight Aids, Tuberculosis and Malaria – the Global Fundor GFATM and Global Vaccines Alliance – GAVI) and foundations (mainly the Bill and Melinda Gates Foundation –the Gates Foundation or BMGF) in the

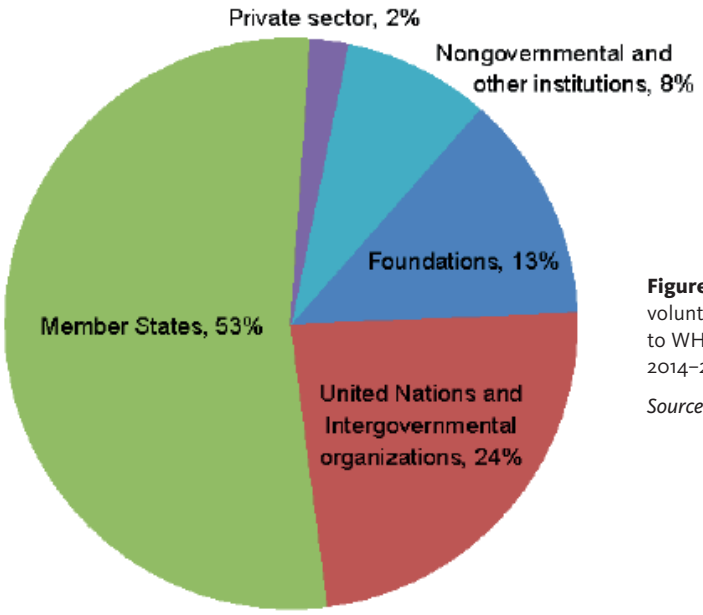

Figure D1.3: Revenue from voluntary contributions to WHO's budget for 2014–2015, by source

Source: WHO (2016d, p. 23)

form of specified (tied to a particular programme) voluntary contributions (WHO, 2016d). About half of the voluntary tied funding was from countries (with the USA and the UK accounting for the largest share – US$ 305 million and US$ 157 million, respectively) and the rest from other donors, including private foundations, intergovernmental organizations, partnerships and so on (see Figure D1.3).

The imbalance of voluntary in relation to assessed contributions has resulted in the WHO having less flexibility in its budget allocations, and thus in its ability to respond to unexpected challenges and maintain its normative responsibilities. This has been exacerbated as specified funds, those earmarked for particular projects or programmes, increasingly dominate voluntary contributions.

Embracing philanthropic foundations and corporate engagement

Shortfalls in public funding (that is, from member states), both assessed and voluntary, have obliged the WHO to turn to private sources, mainly private and corporate philanthropic organizations. In addition, joint programming with UN agencies, funds and programmes and contributions from pharmaceutical companies are noticeable in the top 20 voluntary, non-state contributors (Table D1.2). Notably none of the non-state contributors provide untied core funds.

As Figure D1.4 shows, the scale of this shift is evident in the fact that after the US government, the Bill & Melinda Gates Foundation (or BMGF) was the organization's largest voluntary contributor in 2015 (WHO, 2016c).

Since it began supporting WHO a decade ago, the BMGF has been contributing between US$ 250 million and US$ 300 million a year. In one year

TABLE D1.2: WHO's top 20 private (non-state) voluntary contributors 2015 (in US$)

Contributor	Voluntary, contributions specified	Other voluntary contributions[a]	Total revenue
Bill & Melinda Gates Foundation	181,820,644	3,451,881	185,272,525
GAVI Alliance	126,421,673		126,421,673
National Philanthropic Trust	86,252,168		86,252,168
Rotary International	56,302,924		56,302,924
UN Development Programme	46,746,622		47,221,524
European Commission	45,637,006		45,637,006
UN Central Emergency Response Fund	42,219,954		42,219,954
UN Population Fund	30,723,860		30,723,860
UN Fund for International Partnerships	19,276,440	705,687	19,982,127
African Development Bank Group	19,105,011		19,105,011
Joint UN Programme on HIV/AIDS	17,936,172		17,936,172
UNITAID – International Drug Purchase Facility	14,923,517		14,923,517
UN Office for Project Services	9,979,445		9,979,445
Bloomberg Family Foundation	8,424,000		8,424,000
Wellcome Trust	7,314,109	94,496	7,408,605
GlaxoSmithKline	7,769,202		7,769,202
Novartis	6,992,742		6,992,742
Carter Center	6,500,000		6,500,000
UN Children's Fund	6,337,126		6,337,126
Sanofi Pasteur	6,158,152		6,158,152

Source: WHO (2016d, p. 25)

Note: [a] Includes contributions to Contingency Fund for Emergencies; Special Programme of Research, Development and Research Training in Human Reproduction; Stop TB Partnership; and Special Programme for Research and Training in Tropical Diseases

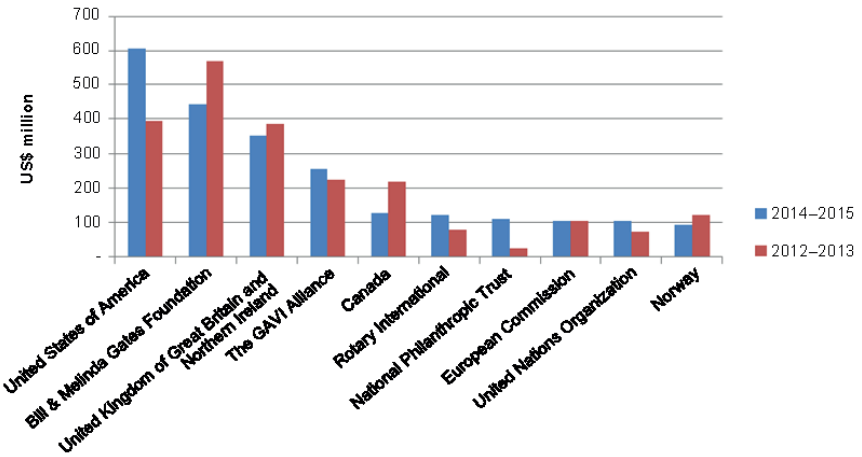

Figure D1.4: Top 10 voluntary contributors to the programme budget 2014–2015 and programme budget 2012–2013 (US$ million)

Source: WHO Programmatic and Financial Report for 2014–15, http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_45-en.pdf

– 2013 – it was the largest donor bar none, overtaking total contributions from the governments of both the USA and the UK.

The impact of funds from private donors is readily apparent in WHO's spending. One of the priorities of the BMGF is the eradication of polio. A breakdown of the WHO's finances reported in 2016 shows that its polio programme is by far the best-resourced, accounting for 23.5 per cent of the WHO's programme budget (Kelland, 2016).

The BMGF's interest in health is not limited to polio. As a founder and principal donor to GAVI, it has pumped money into massive vaccination programmes (see Chapter D4 on GAVI). It is also a substantial supporter of the health programmes of other UN entities by contributing to the UN Foundation, which in turn channels its resources through the United Nations Fund for International Partnerships (UNFIP). Moreover both GAVI and the UNFIP are listed among the top contributors to the WHO, thereby multiplying the channels of influence that the BMGF can leverage upon. The question remains: How does this relate to governance and accountability? Is there such a thing as governance double-dipping?

BMGF has also been criticized in the past for having a negative effect on research systems. In late 2007 in a highly critical memorandum, head of WHO's malaria programme, Dr Arata Kochi, complained to Dr Margaret Chan, the director general of the WHO, that the Bill and Melinda Gates foundation's money, while crucial, could have "far-reaching, largely unintended consequences." He warned that the growing dominance of malaria research by the foundation risks stifling a diversity of views among scientists and wiping out the world health agency's policy-making function. Many of the world's leading malaria scientists are now "locked up in a 'cartel' with their own research funding being linked to those of others within the group," Dr. Kochi wrote. Because "each has a vested interest to safeguard the work of the others," he wrote, getting independent reviews of research proposals "is becoming increasingly difficult." He added, the foundation "even takes its vested interest to seeing the data it helped generate taken to policy." Dr. Kochi, called the Gates Foundation's decision-making "a closed internal process, and as far as can be seen, accountable to none other than itself." He argued, the foundation's determination to have its favoured research used to guide the health organization's recommendations "could have implicitly dangerous consequences on the policy-making process in world health" (McNeil , 2008).

Partners or competitors for health?

The ever increasing role of private voluntary contributions has accelerated the so-called 'partnership model' (essentially involving partnerships between public entities and the private sector, including private foundations) in public health. The GFATM and GAVI are two examples of such mega partnerships and are discussed in other chapters in the volume (see Chapter D4). The

partnership approach and its impact have been the subject of an increasing number of analyses.[1] Clinton and Sridhar (2017b, p.5) observe in this respect:

"The move towards the partnership model in global health and voluntary contributions…allows donors to finance and deliver assistance in ways that they can more closely control and monitor at every stage. [This shift] illustrates three major trends in global health governance more broadly: towards more discretionary funding and away from core or longer-term funding; towards multi-stakeholder governance and away from traditional government-centred representation and decision-making; and towards narrower mandates or problem-focused vertical initiatives and away from broader systemic goals sought through multilateral cooperation".

Targeted donor influence not only results in less flexibility, it also weakens support to leadership driven by independent health considerations and has had a marked effect on undermining the WHO's ability to sustain/maintain adequate expertise and staff capacity. This has been well documented in response to the Ebola crisis and is threatening to undermine the gains in HIV response. In September 2016, the WHO sounded the alarm that due to inadequate finances, the organization is likely to lose expertise and to struggle in providing countries the necessary technical guidance on a number of health issues, such as antimicrobial resistance and HIV/AIDS.

Further, it makes the WHO more vulnerable to influence by rich donor countries, many of them active in promoting the interests of powerful corporations within the health business, especially pharmaceutical companies (see Box D1.1). Margaret Chan (2013) spelled out the pressures faced from corporate influence and 'business interests of powerful economic operators' in the following manner:

"Research has documented these tactics well. They include front groups, lobbies, promises of self-regulation, lawsuits, and industry-funded research that confuses the evidence and keeps the public in doubt.

Tactics also include gifts, grants, and contributions to worthy causes that cast these industries as respectable corporate citizens in the eyes of politicians and the public. They include arguments that place the responsibility for harm to health on individuals, and portray government actions as interference in personal liberties and free choice.

This is formidable opposition. Market power readily translates into political power. Few governments prioritize health over big business…This is not a failure of individual will-power. This is a failure of political will to take on big business".

Impact of voluntary contributions on programme budget allocations

The WHO programme budget for 2016–2017 amounted to nearly US$ 4,400 million for the biennium. Table D1.3 provides details of how specified (earmarked) voluntary contributions are distributed over different programme

Box D1.1: Corporate influence on WHO policies and programmes: how does it work?

Shortly after the WHO had declared the swine flu outbreak (2009–2010) a pandemic, it was reported that some of the experts advising the emergency decision-making committee had ties to drug companies that were producing antivirals and influenza vaccines. The pandemic proved to be a trigger point for pharmaceutical companies to establish vaccine contracts with governments, many of which subsequently lay dormant due to overestimation of the severity of the virus by the emergency committee. This entailed significant costs for countries already facing tight health budgets, and raised serious concerns about potential conflicts of interest. It took the WHO more than one year after the declaration to reveal the names behind the decision-making processes of the committee, with the organization citing the need to protect the experts from external pressures. After a large number of reviews, the question remains: Was it the interests of pharmaceutical companies or concern for public health that was being prioritized? (Cohen and Carter, 2010)

Image D1.3 Protest against land grabbing by TNCs at the UN in Geneva (Claudio Schuftan)

areas. Of the specified voluntary contributions, 84 per cent go to the top 10 technical programmes, while the bottom 10 areas receive just 1.4 per cent of the specified voluntary funds. Clearly donors are cherry-picking the areas they wish to fund. The WHO funnels funding from its core budget to fill the gaps in areas not funded by voluntary contributions, such as the areas of non-communicable diseases, social determinants of health, ageing and gender equity, and especially the new WHO Health Emergencies (WHE) Programme, requested and approved by member states at the WHA in May 2016.

TABLE D1.3: Percentage of specified voluntary contributions to WHO programme area, 3rd quarter, 2016–2017

Polio eradication	35.2
Outbreak and crisis response	15.8
Reproductive, maternal, newborn, child and adolescent health	7.7
Vaccine-preventable diseases	6.5
Access to medicines and other health technologies and strengthening regulatory capacity	4.2
Neglected tropical diseases	3.5
National health policies, strategies and plans	3.4
Malaria	2.8
HIV and hepatitis	2.7
Integrated people-centred health services	2.5
Tuberculosis	2.4
Country emergency preparedness and the International Health Regulations (IHR)	2.1
Health and the environment	1.8
Non-communicable diseases	1.8
Infectious hazard management	1.2
Health systems information and evidence	1.1
Emergency operations	1
Nutrition	0.8
Health emergency Information and risk assessment	0.6
Mental health and substance abuse	0.6
Antimicrobial resistance	0.3
Disabilities and rehabilitation	0.3
Food safety	0.3
Management and administration	0.3
Violence and injuries	0.3
Emergency core services	0.2
Leadership and governance	0.2
Social determinants of health	0.2
Ageing and health	0.1
Gender, equity and human rights mainstreaming	0.1
Strategic communications	0
Strategic planning, resource coordination and reporting	0
Transparency, accountability and risk management	0

Source: WHO (2016a)

It would be incorrect to infer from the data indicating better funding for some programmes (for infectious disease control and eradication, for example) that these are overfunded. Given the WHO's financial situation,

all programmes are inadequately funded. What the data however suggests is that some programmes are grossly underfunded as a consequence of the donor chokehold on the WHO's finances. It is instructive to note that some programme areas, where the WHO has invested considerable effort and attention – such as social determinants of health and non-communicable diseases (NCDs) – receive very little donor support.

Overall, the programmes that donors choose to fund are those where tangible results are simpler to measure. Thus infectious disease programmes and infectious disease eradication receive a bulk of donor support. Donors are more inclined to support actions in areas where they are able to see that their money is 'well spent'. In contrast, areas in which it is difficult to measure outcomes in the short and medium term, irrespective of their importance to public health, receive no support from donors. It can be argued that attention to the social determinants of health or to better nutrition can, in many situations, contribute more to public health outcomes than interventions that focus on particular diseases.

Similarly areas of work that relate to strengthening of health systems are likely to have better long-term benefits than disease-focused programmes. However these are precisely the areas that are ignored by donors. The Burden of Disease (BoD) data is clear regarding the rising burden placed by NCDs, not just in high-income countries (HICs) but also in low- and middle-income

Image D1.4 The World Health Assembly in session in Geneva (Thomas Schwarz)

countries (LMICs). But work on NCDs involves systemic efforts related to health system strengthening and on a range of social determinants such as nutrition, exposure to environmental toxins and so on. Actions in these areas are less amenable to quickly measureable outcomes and hence largely ignored. Similarly the BoD data is unequivocal as regards the very large contribution of mental illnesses and injuries, yet they receive scant support from donors (WHO, 2004).

A telling example of how donor priorities override important decisions taken by member states at the WHO is that of the WHE Programme. It was set up in 2016 in recognition of the need for the WHO to better respond to health emergencies following its tardy response to the Ebola outbreak in 2014. It focuses on building capacity in the areas of early warning, risk assessment and emergency response in order to provide needed services to affected populations and at the same time tackle the root causes of their vulnerability. "Crucially these strategies must be integrated with health-systems strengthening. The health system as a whole provides the foundation on which to build the International Health Regulations (IHR) core capacities required to raise readiness and resilience across the board" (WHO, 2016b, p. 4).

Financing for the US$ 485 million WHE Programme is drawn from core funds for baseline staff. The US$ 100 million WHO Contingency Fund for Emergencies (CFE) has a funding gap of US$ 68.5 million and the WHE is the most critically underfunded WHO programme, with a deficit of 56 per cent of requirement (WHO, 2016b, p. 13). At a special session in October 2016 to address the funding gap, Margaret Chan noted that "the organization has been asked to do more, specifically through WHE, while income from voluntary contributions has not increased and core voluntary contributions income has actually decreased".

The WHO has emphasized that the CFE has been critical in enabling the organization to quickly respond to emergencies, particularly in the early stages, rather than wait for humanitarian appeals. The problem with its design, based on front-loading funds and asking the WHO to fundraise to reimburse has not been successful, either because "appeals are not fully financed or donors do not agree to direct their funds to reimburse the CFE but only for additional activities" (WHO, 2016b, p. 14). Clearly, evidence from its limited tenure indicates that the new WHE Programme has suffered from many of the same flaws that it was designed to address, namely funding that is inadequate, highly specified and not sustainable.

Consequences beyond global public health

The WHO was set up as a global authority, so nations would "compromise their short-term differences in order to attain the long-run advantages of regularized collaboration on health matters" (Clinton and Sridhar, 2017b, p. 6). However, this approach is frequently challenged as member states have

disagreed about the primary work of the organization. While some member states have prioritized the need for strong public health institutions and broad health coverage, others have argued for a more 'selective' approach, concentrating attention on eradicating specific diseases, through coordinated intervention by a number of sources, public and private.

In the resulting turmoil, the WHO has lost its political importance relative to new actors in the global health arena. From being the foremost – and virtually the only – authority on global health in the first decades of its existence, the WHO now stands amongst a growing number of public and private actors, initiatives and international partnerships in health, including the GFATM, GAVI, UNAIDS and especially BMGF. Some member states, led by the USA and other HICs, have been instrumental in driving health initiatives outside the WHO, such as to the problem-focused vertical funds (GAVI and the GFATM) and to some extent the World Bank, without consideration of the impact on the norm-setting role and importance of public and preventive health systems, which are intimately connected to human rights and to reducing inequalities (income and non-income). This phenomenon has affected many UN entities in the last 10 to 15 years. The resulting decline in effectiveness, most notably in the case of Ebola, has had a negative impact on the UN development system as a whole and has encouraged a myriad of special initiatives outside the UN. At the same time, other international organizations such as UNICEF and the World Bank have expanded their role in health and have at their disposal significant resources for programme implementation.

Shift in governance: member state-driven to multi-stakeholder

The shift in funding strategy – from assessed to voluntary to specified – has been instrumental in redirecting the work of the WHO. It also raises some important issues beyond public health: first and foremost those of policy coherence and democratic governance. Concern about this shift was echoed by Margaret Chan: "When private economic operators have more say over domestic affairs than the policies of a sovereign government, we need to be concerned" (WHO, 2014). The vicious circle evident in the WHO is also at play in many parts of the UN system. When unable to ignore the enormous gap between the demands placed on the UN system and the resources contributed, most governments (and non-state actors) have responded with earmarked funds or with partnership arrangements sometimes, thus diluting or ignoring the norms and standards that are the hallmark of the UN. Few governments follow the good practice evidenced by Sweden, which made a core voluntary contribution of US$ 25.88 million in 2016. This was over 30 per cent of the core voluntary contributions from all countries put together (WHO, 2017). Traditional donors seem to favour the partnerships approach and resource non-UN entities in areas that should be UN-led. This financing strategy further fragments programme design and delivery, undermines the

normative authority of the UN, and not only encourages competition among UN entities, but sets up and nourishes programmes parallel to and competing with the UN programmes.

The growing dependence of the WHO on funding beyond core assessed contributions from member states and the increasing importance of contributions from non-state actors (foundations being the main source) has provided impetus to move towards a governance structure in the WHO that is able to accommodate entities other than member states. The modified strategy towards governance is evident in Margaret Chan's observation:

"If multisectoral collaboration and multi-stakeholder engagement are the reality for sustainable development in the post-2015 era, we need to debate what type of mechanisms are required to allow all stakeholders to make contributions and to protect against the influence of vested interest. We also need to consider the UN's role as an honest broker that promotes fair play" (WHO, 2014).

The WHO, thus, has clearly embarked on a path where, as in other UN agencies, a member state-driven governance system is being replaced by a 'multi-stakeholder governance' system.

The Framework for Engagement with Non-State Actors (FENSA), passed by the WHA in 2016 has been characterized as "opening the floodgates to corporate influence on global and national decision-making processes in public health matters" (Hawkes, 2011). A civil society statement raised the following concerns regarding how FENSA is poised to modify the governace of WHO (Civil Society Statement 2016):

"FENSA, in its overarching section puts private sector entities on an equal footing with other NSAs [non-state actors], failing to recognize their fundamentally different nature and roles. It uses the principle of 'inclusiveness' for all five 'types of interactions' (resources, participation, evidence, advocacy and technical collaboration) to all NSAs. When applied to major transnational corporations, their business associations and philanthropic foundations, this categorization of interactions, combined with an alleged right to inclusiveness, will once and for all, legitimize the framing of public health problems and solutions in favour of the interests and agendas of those actors.

FENSA, for example, proposes technical collaboration with the private sector, including capacity building, with no adequate safeguards. It seems that there is opposition from developed countries to a clause that would exclude private sector resources for activities such as norms and policies development and standard setting. FENSA removes the existing minimum restrictions on accepting financial resources from the private sector to fund salaries of WHO staff. If the WHO relies on funds from the private sector for any operational expenses, it risks showing favouritism towards those sectors in its standard-setting, expert advisory, and other public health functions."

Concluding observations

As has been outlined, the WHO has had a series of financing crises making it unable to fund its swelling mandate. Two shifts represent milestones in what has become a deep-seated undermining of the global health authority: the shift from assessed to voluntary contributions and the shift within voluntary to specified contributions.

While member states have agreed to a series of reform measures to address these shifts and to encourage increased funding, these measures have continued the pattern of fragmentation and resulted in pushing the WHO further from its core role as global health authority. Moreover, the shift in financing weight from assessed and flexible contributions to specified contributions, the overwhelming influence of a few donors, and the empowering of non-state 'partners' has undermined the importance and leadership of public health authorities.

As the health world is further fragmented, its institutions often competing rather than cooperating with each other, this has enhanced the influence of a few big donors, including powerful member states such as the USA and UK as well as private actors, notably the BMGF (Clinton and Sridhar, 2017b, p. 7).

There is an urgent need for a transition strategy to re-position the WHO as a primary and central health authority, and break donor control, public and private, of the health sector. The vital next steps are for member states and the WHO leadership to develop and implement a transition strategy to reconstitute assessed and core, supplemented by flexible financing.

Some elements of a transition strategy are as follows:

- Member states must reverse the trend towards voluntary specified contributions and reliance on private sector financing.
- Payment of assessed contributions must be in full and on time.
- The maximum of allowed voluntary specified contributions per donor must be established at 50 per cent (of the total contribution by the donor).
- There should be agreement on a multi-year strategy to move towards a 50/50 ratio for voluntary flexible and voluntary specified contributions.
- A threshold of assessed or voluntary flexible contributions must be set for eligibility to make voluntary specified contributions (VCS). For member states, no VCs should be allowed unless fully paid up on assessed contributions. For non-state partners, no VCs to be allowed unless an equal voluntary flexible contribution is made.
- Contributions from non-state 'partners' must be accompanied with signed agreements that guarantee commitment to UN standards, in particular to not engage in other programmes and funding that undermine the achievement of the WHO and UN mandates, including the achievement of the Sustainable Development Goals (SDGs). Violations would result in expulsion from partnerships and forfeiture of contributions, and non-eligibility for contractual and procurement options.

- FENSA must be refined to distinguish between non-state partners in general and dominant donors. The latter need to comply with a distinct agreement as befits their size and influence.

The WHO is not alone among UN agencies in needing to implement a strategy that 'contains' contributions from donors within the UN standards and ensures respect and support for norm-setting, multilaterally designed and accountable programmes, and democratic governance. With the shift to operational and implementation control by donors and their various stakeholder partners, rights-based approaches and the governing role of member states in the public interest are being undermined, often intentionally.

The size and power of some corporations and foundations and their national enablers drive the status quo from which they benefit, and make transformative changes in governance and financing more difficult. In addition to entity-specific strategies, member states and the UN leadership must be active promoters of the public interest and the replenishment of essential public resources.

The WHO, like other UN entities, has been a victim of the shift in funding patterns by member states. An organization struggling for finance is more likely to accept or cooperate with a variety of approaches that bring or promise resources. This further fragments programming, decision-making and capacity. The major challenge facing the UN development system is how to spark and sustain the political leadership needed to break the vicious circle whereby responses to the chronic financing situation are actually exacerbating it.

Note

1 See chapter on the Gates Foundation in this volume and the work of the Global Policy Forum at https://www.globalpolicy.org/

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