Voluntary Contributors, Priority Setting, and Resource Allocation at the World Health Organization

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INTRODUCTION

Global Health

The term global health is oft used to describe a host of activities on the international stage relevant to public health. From addressing the challenging cross-border issues of infectious diseases and maternal & child health to the strengthening of national health systems, the term global health is conjured up as a descriptor of the overarching work being done. From a theoretical standpoint, global health is poorly defined and varied in meaning and purpose depending on the health care providers, researchers, and funders that work in this field\(^1\,^2\). Koplan et al. state that a clear and universal understanding of global health is important to guide stakeholders from a philosophical, strategic, and priority-setting framework: “…if we do not clearly define what we mean by global health, we cannot possibly reach agreement about what we are trying to achieve, the approaches we must take, the skills that are needed, and the ways that we should use resources”\(^1\).

The Need for an International Health Organization

This is all to say that global health is indeed a vast and complex field. When you think of the various social, economic, genetic, and environmental determinants of health, it is not difficult to be overwhelmed. Addressing the health of the world’s 7 billion people is not an easy feat. Not
unlike other fields of study, one’s practice can be made more understandable and translatable when standards are set and guidelines established. To serve this purpose the United Nation’s (UN) largest specialized agency, the World Health Organization (WHO), was founded in 1948.

A Very Brief Background of the World Health Organization (WHO)

The WHO is “the coordinating authority on international health”. It’s founding objective, articulated in Article 1 of the WHO Constitution, has not changed: “the attainment by all peoples of the highest possible level of health”\textsuperscript{4,5}, nor has the way it defines health: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”\textsuperscript{5,6}.

However, over recent years the WHO’s credibility as the world’s standard setter in health has come under intense security. A growing body of stakeholders describe have the WHO as a slow-moving bureaucracy lacking innovation\textsuperscript{4}, leadership\textsuperscript{8}, and transparency in the allocation of its resources\textsuperscript{4}.

The Issue of Funder Influence within the World’s Health Organization

There is mounting concern that the WHO’s ability to carry out the functions it was created for 66 years ago has been impaired amidst a crowded and well-funded field of mega-
foundations in global health\textsuperscript{4,7,8}. The organization has become increasingly reliant on the financial support afforded to it by ‘non-State actors’\textsuperscript{9,10,11}, particularly the World Bank\textsuperscript{2} and the Bill and Melinda Gates Foundation (Gates Foundation)\textsuperscript{10,11}.

The 'political' influence of non-State Actors has weakened the WHO’s role as a leader in global health issues. The large earmarked financial contributions of these mega-foundations, have distorted the Organization’s ability to carry out its core functions, which include:

1. objectively shaping the agenda for health research;
2. setting norms and standards for health;
3. developing health care policy options that are informed by evidence;
4. and provide essential assistance for governments worldwide in serving and protecting the health of their citizens.

In light of the challenges discussed prior, during the Sixty-fourth World Health Assembly (WHA) in 2011 the WHO’s Director-General, Dr. Margaret Chan, announced that the Organization would be undergoing a heavy reform of its activities\textsuperscript{12}.

At a time when these reform activities are underway, the aims of this paper are to review the role of the WHO in global health and priority setting, the challenges it faces from relationships with external funders, and the steps being taken to overcome these challenges.
The WHO is made up of 193 Member States or ‘State Actors’. Based in Geneva, Switzerland is a Secretariat composed of approximately 2,400 technical and administrative staff. A further number of staff are distributed across 6 Regional Offices worldwide (Figure 1). Including the public health experts working at the WHO’s 147 country offices, the number of staff increases to more 8,500.14

Financing at the WHO has undergone a transformation that began in the late 1980s. Traditionally, funding of the Organization came from contributions from Member States based on their population and gross domestic product. This form of financing, also referred to as the ‘regular budget’, came to be accompanied by extrabudgetary funding from non-State Actors. The rise in extrabudgetary funding began equating with the regular budget—$437 million versus $543 million, respectively—from 1986-1987 onwards. By the 1990s the regular budget had been surpassed by $21 million, with non-State Actors contributing to 54% of the WHO’s total budget3,12.
This influx of financial support in the form of donations and philanthropy would be a welcome boost to the budgets of most large health organizations. However, in the case of the WHO, these extrabudgetary resources did not come free of terms and conditions. WHO Member States only have control on the allocation of funds that derive from the regular budget\(^2\). This means that non-State Actors have the power to make the decisions regarding the allocation of extrabudgetary funds, and as these contributions increase, so does the influence of these non-State Actors on setting the priorities and agenda of the WHO. Confounding this issue, extrabudgetary funds fluctuate from year to year, meaning that it is difficult to plan and budget in advance\(^2\), which is vital when your objective is to set the agenda for international health.
In 1990, the World Bank’s financial contributions to the WHO were by themselves above the WHO’s total operating budget\textsuperscript{12}. Using these extrabudgetary contributions the World Bank began developing a series of programs within the WHO that were independent of the Organization’s established activities. These programs were largely inaccessible to WHO decision-making powers, making it increasingly difficult for the Organization to develop collaboration with existing activities, although overlap almost certainly existed. The Bank’s ability to mobilize large financial resources gave it significant leverage over the WHO, meaning that the WHO’s Constitutional function “to act as the directing and co-ordinating authority on international health work” was in demise\textsuperscript{5}. Brown et al. (2006) describe the situation in the 1990s as: “WHO is caught in a cycle of decline, with donors expressing their lack of faith in its central management by placing funds outside the management’s control. This has prevented WHO from [developing] . . . integrated responses to countries’ long term needs”\textsuperscript{2}.

The impact of non-State Actors on the WHO’s resource allocation activities has not faded over time. In the modern era, the Gates Foundation, is by far the largest non-State Actor in international health\textsuperscript{10}. It was founded in 2000, and as of 2006 had endowed $60 billion in funds internationally. Between 1999 (\textit{Bill Gates’ former foundation was donating prior to 2000}) and 2007, the Gates Foundation granted over $330 million to the WHO\textsuperscript{10} (Table 1), and as of 2012 was the 2nd largest donor to the WHO’s budget behind the United States. The influence of the
Gates Foundation on WHO decision-making has been described as domineering: “You can’t cough, scratch your head or sneeze in health without coming to the Gates Foundation. And the people at the WHO seem to have gone crazy. It’s ‘yes sir’, ‘yes sir’, to Gates on everything”\textsuperscript{10}. In 2008, the \textit{New York Times} broke a story in which the head of the WHO’s malaria program cited serious concerns that the Gates Foundation’s funding of world’s leading malaria scientists was hampering the ingenuity of the research being done and the policymaking ability of the WHO\textsuperscript{10}.

\textbf{Table 1}. Top 10 Grant Recipients of Gates Foundation Resources from 1999-2007\textsuperscript{10}

<table>
<thead>
<tr>
<th>Organization receiving grant(s)</th>
<th>Cumulative Amount awarded (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAVI</td>
<td>1,512,838,000</td>
</tr>
<tr>
<td>PATH</td>
<td>824,092,352</td>
</tr>
<tr>
<td>Global Fund</td>
<td>651,047,850</td>
</tr>
<tr>
<td><strong>World Health Organization</strong></td>
<td><strong>336,877,670</strong></td>
</tr>
<tr>
<td>Medicines for Malaria Venture</td>
<td>202,000,000</td>
</tr>
<tr>
<td>John Hopkins University</td>
<td>192,320,238</td>
</tr>
<tr>
<td>IAVI</td>
<td>153,780,244</td>
</tr>
<tr>
<td>University of Washington</td>
<td>151,973,070</td>
</tr>
<tr>
<td>Institute for One World Health</td>
<td>144,825,148</td>
</tr>
<tr>
<td>World Bank Group</td>
<td>134,486,883</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,304,241,455</strong></td>
</tr>
</tbody>
</table>

The Gates Foundation is not the only external influence on the WHO today. For the 2011-2012 fiscal year, approximately 30\% of the WHO’s $4.9 billion (USD) budget came from private and voluntary government grants\textsuperscript{9}. In addition to mega-foundations, Member States are
able to have an unbalanced influence compared to less economically prosperous nations when it comes to what should be a democratic process of resource allocation. Powerful Member States have the ability to earmark their voluntary contributions for purposes that suit their interests, which may or may not be in the best interest of the international community.

**THE NEED FOR REFORM AT THE WORLD HEALTH ORGANIZATION**

In 2011, amidst escalating concerns at the WHO regarding structure, credibility, and financial stability, Dr. Margaret Chan announced a Member State-driven reform process. Meetings were conducted to inform staff and collect input on the reform process. The Executive Board received papers on potential aspects of reform, and decided to consider nine to generate a consolidated report for the 65th WHA on what the reform process would entail. Some of the proposals given the green light included:

- development of criteria for priority setting within the WHO;
- engaging more public health stakeholders (i.e. private sector, foundations, civil society);
- setting up a contingency fund for public health emergencies;
- clarifying roles between various WHO offices;
- and developing an evaluation framework that is independent.
Subsequent to this, Member States met to agree upon categories or work and criteria that would be used to set WHO priorities. A Consolidated Reform Report, a new Programme of Work, and a draft Implementation Framework, were presented by the Director-General at the 65th WHA. Member States were given just over a month to discuss the Programme of Work and budget and at the end of 2012 the Programme, Budget and Administration Committee of the Executive Board (PBAC) met to discuss WHO financing. As of April 2013, the reform process has been ongoing for over 2 years, with three core objectives in mind:

1. An enhanced commitment to meet the health priorities of Member States;

2. Improved Organizational governance to increase ability to provide clarity in global health messaging;

3. Management reforms to bring the Organization in line with its Constitution.

The reform process for priority setting at the WHO has truly been driven by Member States. Member States have the opportunity to provide to the WHO Executive Board recommendations on the categories, methodology, criteria, timelines, and priorities for programs (defined in Table 2). The Executive Board submits these recommendations to the WHA for further consideration by all Member States on what shall be incorporated into the WHO’s ‘General Programme of Work’. Programmes of Work vary in length of duration and purpose.
The *Eleventh General Programme of Work 2006-2015* is intended to develop a global health agenda\textsuperscript{14}.

The most important component of the WHO’s priority setting process is the ‘Biennial Programme Budget’. The Programme Budget is guided by the Programme of Work and the Constitution of the WHO. The Constitution provides a broad outline of the Organization’s work, and while technical focus may shift based on Programmes of Work and Budgets, the functions outlined in Article 2 of the Constitution\textsuperscript{14} (Appendix 1) remain fixed; similar to the *Mission, Vision, and Values* statement of a corporation.

**DISCUSSION**

It is apparent that the WHO has been through, and continues to experience, serious challenges regarding resource acquisition, priority setting, and resource allocation. The evolution of non-State funders and voluntary government financing by wealthy nations has been a blessing and a curse for the Organization. While the increased budget has allowed the Organization to allocate more resources, this has been done in a pseudo-fashion whereby external groups have either set the priorities themselves or been able to unfairly influence the WHO’s decision-making. If the WHO is to return to its rightful place as the coordinating authority for
international health, it must begin a radical shift in organizational values, structure, and processes. Fortunately, the reform process currently underway demonstrates the WHO has recognized the issue and is willing to begin laying a foundation for more effective, efficient, and transparent priority setting and resource allocation.

Similar to most large-scale priority setting activities, the WHO’s reform process has come at a cost. Up to 34% of employee positions at the Geneva Headquarters were cut in 2011\textsuperscript{15}. A number of these released employees are considering wrongful dismissal cases against the WHO, with Matthew Parish, a lawyer for many of these employees, stating: “These are absolutely extraordinary cutbacks—pretty much unprecedented in the public and private sector”\textsuperscript{15}. According to the International Labour Organization (ILO), compensation packages for those effected could amount to $500,000 (USD), which would be a substantial hit on the WHO, and likely offset any savings the cuts had in the first place\textsuperscript{15}.

Anecdotally speaking, during my time as an Intern at the WHO from May to August 2013, the Director-General made several attempts to ease organizational tension. Dr. Chan held frequent Town Hall Meetings for employee discussions, initiated a monthly newsletter to provide updates on the reform process, and an Organization-wide “Stakeholder Perception Survey” conducted independently by \textit{Grayling}, an international communications organization. Despite
the mounting tensions, Dr. Chan has openly stated that further staffing cuts are imminent given the restructuring of organizational governance.

Table 2. Definitions of key terms used in the reform of the WHO’s programme budgeting and resource allocation reform

<table>
<thead>
<tr>
<th>Terms</th>
<th>Definitions</th>
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<tbody>
<tr>
<td>Categories</td>
<td>“represents broad groupings of WHO’s work and set out the scope and boundaries of WHO’s work. Taken together, they provide a framework for setting priorities (both between different categories and within each category), their wording providing a sense of purpose, strategic orientation and specific direction.”</td>
</tr>
<tr>
<td>Core functions</td>
<td>“describes ‘how’ WHO works (e.g. by providing technical support, setting norms and standards). Core functions derive directly from Article 2 of the WHO Constitution and are therefore relatively fixed even if the substantive technical focus of WHO’s work changes over time.”</td>
</tr>
<tr>
<td>Criteria</td>
<td>“are factors to be taken into account in determining priorities. Different sets of criteria are used in developing priorities for different purposes, for example in developing the general programme of work including strategic objectives, the programme budget and the country cooperation strategies.”</td>
</tr>
<tr>
<td>Methodology</td>
<td>“used in priority setting describes how different criteria are used quantitatively or qualitatively in reaching decisions about priorities. An explicit methodology makes priority setting more objective, systematic and transparent.”</td>
</tr>
<tr>
<td>Priority setting</td>
<td>“relative weight given to categories and functions in light of predefined criteria applied through a given methodology to make decisions on greater programmatic emphasis and special consideration in terms of resource allocation.”</td>
</tr>
</tbody>
</table>

The WHO has an aging employee body, meaning that a process of attrition could reduce organizational fear and mitigate potential lawsuits. In addition, there needs to be a culture change within the Organization, and a move away from the notion that voluntary contributors must be appeased in the priorities set and allocation of their contributions. As an Organization that sets norms and standards, the WHO must be impartial and base its policies, decisions, and
recommendations on the best available evidence internationally. Country specific circumstances (i.e. burden of disease, age, and gender composition) must be factored into the decision making process so that WHO established guidelines and recommendations are effective and sustainable. Culture change is also required around the idea that increased funding is a necessity to meet global health demands. With a monitoring and evaluation framework in programs, the WHO will have the enhanced capacity to assess where there are efficiency gains, allowing them to make informed decisions regarding which resources can be removed and potentially reallocated to priority areas, without program performance suffering. The notion of ‘allocating resources at the margins’, is a practice whereby priority setting allows unexpected resources to be gained and reallocated to achieving marginal benefits in priority areas; an activity beneficial for all healthcare organizations regardless of size.

**CONCLUSION**

Global health is a vast field incorporating a diverse group of stakeholders. The World Health Organization is in a unique role as it is tasked by the global community to oversee health and well-being of over 7 billion people. To be an effective international health organization in a world with limit financial resources the WHO needs to conduct its work in a systematic fashion free from bias and unbalanced third-party influence. The challenge of looking out for the health
of the international community is compounded by voluntary contributors and the influence they hold on resource allocation. However, these challenges are not without solutions. Changes in organizational culture and structure, and an established priority setting framework, are necessary steps the WHO must take to build truly collaborative partnerships with these funders. It is only through being dedicated to establishing transparent business practices and renewed commitment to founding Constitutional values that the World Health Organization will be able to regain its credibility and pre-eminence in ‘global health’.
APPENDICES

Appendix 1. The 22 core functions of the WHO as defined in Article 2 of the WHO Constitution

“In order to achieve its objective, the functions of the Organization shall be:

a) to act as the directing and coordinating authority on international health work;
b) to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate;
c) to assist Governments, upon request, in strengthening health services;
d) to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments;
e) to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories;
f) to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services;
g) to stimulate and advance work to eradicate epidemic, endemic and other diseases;
h) to promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries;
i) to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene;
j) to promote co-operation among scientific and professional groups which contribute to the advancement of health;
k) to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform
l) such duties as may be assigned thereby to the Organization and are consistent with its objective;
m) to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment;
n) to foster activities in the field of mental health, especially those affecting the harmony of human relations;
o) to promote and conduct research in the field of health;
p) to promote improved standards of teaching and training in the health, medical and related professions;
q) to study and report on, in co-operation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security;
r) to provide information, counsel and assistance in the field of health;
s) to assist in developing an informed public opinion among all peoples on matters of health;

 t) to establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices;

 u) to standardize diagnostic procedures as necessary;

 v) to develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products;

 w) generally to take all necessary action to attain the objective of the Organization.”

Appendix 2a. WHO Revenue 2010-2011

Appendix 2b. WHO Expenses 2010-2011
WORKS CITED


