Extract from the civil society report
Spotlight on Sustainable Development 2018
www.2030spotlight.org

SDG 3

The need to strengthen public funding for the WHO

BY K M GOPAKUMAR, THIRD WORLD NETWORK (TWN)

A strong and dynamic World Health Organisation (WHO) is critical for the achievement of the SDGs, especially SDG 3 on health and well-being. The WHO constitution mandates the organization "to act as the directing and co-ordinating authority on international health work".[1] However, its ability to fulfil this mandate is circumscribed by the nature of its financial resources. WHO's biennial budget for 2018-2019 is US$ 4.42 billion,[2] just over a quarter of the total sales of the top-selling medicine Humira (Adalimumab) in 2016 (US$ 16.08 billion).[3]

In part this is because many of the organization's donors share the view that WHO may not need a huge budget to carry out its constitutional mandate, which mainly consists of setting norms and standards in the area of public health. However, a large part of the organization's spending in 2016-2017 went to activities related to service delivery rather than to norms and standard setting. For example, US$ 1.16 billion (25.67%) was spent on its polio eradication programme.[4]

Nature of the WHO financing

WHO's budget comprises two categories of funds, namely, flexible funds and specified voluntary contributions. Flexible funds are unspecified resources, which can be allocated according to budget priorities. These funds fall into three categories: assessed contributions, core voluntary contributions and programme support costs. The specified voluntary contributions can be used only for the specific purposes agreed by the donor and the WHO Secretariat.

Over the years specified voluntary contributions have constituted the major portion of the WHO budget. During 1998-1999 the breakdown of assessed and voluntary contributions was 49 percent and 51 percent. During 2016-2017 the share of assessed contributions has fallen to 18.45 percent, while that of core voluntary contributions and programme support costs was 3.37 percent and 6.75 percent, respectively.[5] The major portion of assessed contributions is allocated to salaries – 78 percent during 2010-2011, while only 26 percent of voluntary contributions went to pay salaries,[6] the rest going to programme activities.

The progressive reduction of the share of assessed contributions in the WHO budget has resulted in donor-driven programme implementation, which has often neglected public health needs. The freeze on UN assessed contributions in 1985, initiated by the USA, greatly contributed to this shift.[7] There were attempts on several occasions to increase assessed contributions, but these largely failed. Major donor countries

1 Constitution of the WHO, Chapter II, Article 2 (a).
2 WHO (2017a).
3 https://news.abbvie.com/news/abbvie-reports-full-year-and-fourth-quarter-2016-financial-results.htm
4 Financial flow information is available at the WHO Budget Portal for 2016-17 http://open.who.int/2016-17/budget-and-financing.
5 Ibid
6 WHO (2011a).
7 See for instance Taylor (1991); Adams (2017).

often use voluntary contributions and secondments to influence WHO programmes. Even though there is a stipulation that voluntary contributions can be accepted only for those activities that fall within the WHO General Programme of Work (GPW), this still allows donors to pick and choose programmes within the GPW.

For instance, major donors showed little interest in funding the implementation of activities within the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA), which is designed to make use of trade related intellectual property rights (TRIPS) provisions on public health to ensure access to patent-protected medicines and vaccines, included as target 3.b under SDG 3.

In addition, donors have been able to influence WHO programmes through staff secondments that join the WHO Secretariat. For instance, a former Swiss intellectual property negotiator was seconded to WHO as part of the team to implement GSPOA. Considering the active engagement of the Swiss government in negotiating intellectual property rights this raised an obvious conflict of interest. Similarly, the leader of the Swiss delegation to WHO was seconded to lead the work on WHO's Framework of Engagement with non-State Actors (FENSA).[8] The same person as leader of the Swiss delegation stated at the WHO Executive Board in 2012:

> Increased stakeholder engagement was also welcome, but given the specific characteristics, roles and interests of nongovernmental, private-sector and other organizations, WHO should avoid differentiating between categories of stakeholders.[9]

These secondments clearly raise concerns with regard to conflicts of interest, making it important to increase transparency regarding secondments from the Member States and others to the WHO.

Even though secondments from the private sector to the WHO Secretariat are prohibited there is no such restriction on other non-state actors (NSA), such as the Bill & Melinda Gates Foundation.[10]

Contributions from non-State actors

In terms of non-State contributions, in 2016-2017 the breakdown of voluntary contributions from non-State actors was as follows: Philanthropic foundations 13.1 percent, non-governmental organizations 5.8 percent, private sector 0.99 percent, academic institutions 0.17 percent.[11]

The low share of contributions from the private sector is not proportionate to the level of influence they exercise on WHO decision-making, including standards and norm setting. Transnational corporations in particular have helped to shape these. For instance, WHO's Regulatory System Strengthening (RSS) team, which is part of the Essential Medicines and Health Products Department, has engaged organizations linked to the pharmaceutical industry to draft and consult on a guideline on Good Regulatory Practice (GRP) for national medical products regulatory authorities.[12]

In an effort to avoid undue influence of the private sector on norm and standard setting, the Framework for Engagement with non-State Actors (FENSA)[13] prohibits financial and in-kind resources from the private sector for normative work. Another important condition is that "if a contribution is used for activities other than normative work in which the private sector entity could have a commercial interest, the public health benefit of the engagement needs clearly to outweigh its potential risks."[14]

However, this prohibition on receiving financial resources from the private sector does not completely

8 www.ip-watch.org/2012/08/30/silberschmidt-joins-who-as-senior-adviser-to-director-general

9 WHO (2012), p. 90.

10 WHO (2017b), p. 2.

11 http://open.who.int/2016-17/budget-and-financing

12 Gopakumar (2016).

13 WHO (2016a).

14 http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_ACONF11-en.pdf, p. 26

insulate the WHO from the private sector influence because there is no similar prohibition on financial resources from private foundations, such as the Bill & Melinda Gates Foundation. Between 2014 and 2017, the Gates Foundation has granted more than US$ 1 billion to the WHO,[15] making it the second largest funder of the WHO, behind the USA.[16]

At the same time, the Gates Foundation has investments in many pharmaceutical and food and beverage companies, such as Pfizer and Novartis as well as Coca-Cola. The 2015 tax returns of the Bill and Melinda Gates Foundation Trust[17] show it holds shares and corporate bonds in pharmaceutical companies Pfizer (US$ 719,462 base market value), Novartis AG REG (US$ 6,920,761), Gilead Sciences (US$ 2,920,011 base market value , Glaxo Smith-Kline (US$ 1,589,576 base market value), BASF (US$ 4,909,767), Abott Laboratories (US$ 507,483), Roche (US$ 7,760,738), Novo Norisdick A/S B (US$ 6,208,992), and Merck (US$ 782,994).[18] These holdings have not prevented WHO from collaborating with the Gates Foundation to develop, for instance, the Global Vaccine Action Plan, adopted by the World Health Assembly in 2012, despite the fact that many of these firms benefit from this Action Plan.

WHO reform and financing

After kick-starting the WHO reform process in 2011, there was no focused discussion on the effective ways of increasing the flexibility of resources such as increasing the share and volume of assessed contributions. The flexibility of finance was addressed as part of managerial reform in 2011, which set as an aim to increase the percentage of the WHO's budget that is predictable to at least 70 percent after completion of the reform process.[19] However, the 2011 outcome document on the future of financing for WHO emphasized enlarging the donor base instead of an increase in assessed contributions. It stated:

> Many of WHO's traditional donors face their own budgetary pressures. WHO will therefore seek to attract new donors and explore new sources of funding. In exploring new sources of funding, the aim will be to widen WHO's resource base, for example, by drawing on the Member States with emerging economies, foundations and the private and commercial sector, without compromising independence or adding to organizational fragmentation.[20]

The Executive Board decided to explore the possibility of a collective financing approach designed to secure a shared commitment by the Member States through "an inclusive, proactive, systematic, coordinated and transparent process to ensure predictable financing through finance dialogue". [21]

However, the inability to respond adequately to emergencies like the Ebola outbreak in 2014-2016 forced the Director-General to propose an increase in assessed contributions for the 2016-2017 budget. After several attempts to increase the assessed contributions by 10 percent, including in 2013 and 2015, Member States did agree to increase the assessed contributions by 3 percent for the 2018-2019 budget. While this can be seen as a recognition of the funding crisis, it is totally inadequate in terms of addressing it.

The new General Programme of Work endorsed by the 71st World Health Assembly in 2018 also does not include any specific proposals to enhance flexibility but states only that "demonstrating impact will strengthen the case for investing resources over and above the assessed contributions". Acknowledging that greater flexibility is critical to achieving the General Programme of Work it states that "WHO will seek good-quality, multi-year funding with greater flexibility" and adds: "The Director-General has asked Member States to un-earmark their contribu-

15 WHO (2016b). For more on the role of the Gates Foundation in shaping WHO priorities, see Adams (2017).

16 See: http://extranet.who.int/programmebudget/Biennium2016/Contributor

17 See www.gatesfoundation.org/~/media/GFO/Who-We-Are/Financials/B200_BMGFT_FED_Form-990PF-Public-Disclosure_2015.pdf?la=en.

18 TWN (2017).

19 WHO (2011c), p. 26.6.

20 WHO (2011b), p. 13.

21 WHO (2011c).

tions. This is a sign of trust and enables management to deliver. Increasing assessed contributions would also give WHO greater independence."[22]

Conclusion

Even though a substantial share of WHO funding comes from Member States there is no sustainability and flexibility of funding because a substantial percentage of this funding comes as specified voluntary contributions. This problem is exacerbated by contributions from non-State actors that are overwhelmingly specified, such as the contributions from the Gates Foundation as well as from pharmaceutical companies like GlaxoSmithKline, Novartis and Sanofi Pasteur, all of which are among the top 20 voluntary contributors.

Therefore, there is still an urgent need to ensure sustainable and flexible financing of the WHO. In this regard the following three points should be essential elements of any WHO financing campaign:

- First, the assessed contributions by Member States should be increased every year.
- Second, a certain specified percent of the contributions from philanthropic foundations, NGOs and academic institutions should be accepted only in the form of core voluntary contributions.
- Third, contributions from the private sector should be accepted only as core voluntary contributions.

References

Adams, Barbara (2017): Money Talks at the WHO. In: Global Health Watch #5. London: Zed Books. www.zedbooks.net/shop/book/global-health-watch-5/

Gopakumar, K M (2016): Pharma-linked organisations involved in WHO Guideline drafting. Geneva: Third World Network. www.twn.my/title2/health.info/2016/hi160507.htm

Taylor, Paul (1991): United Nations System Under Stress: Financial Pressures and their Consequences. In: Review of International Studies 17:4 (Oct. 1991), pp. 365-382.

TWN (2017): WHO: Civil society calls for deferment of "official relations" status to Gates Foundation. Geneva. www.twn.my/title2/health.info/2017/hi170104.htm

WHO (2018): Draft Thirteenth General Programme of Work (Doc. A71/4). http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf

WHO (2017a): Programme budget 2018-2019. Geneva. www.who.int/about/finances-accountability/budget/PB2018-2019_en_web.pdf

WHO (2017b): Engagements with non-State actors. Report by the Director-General. Geneva (Doc. EB142/28). http://apps.who.int/gb/ebwha/pdf_files/EB142/B142_28-en.pdf

WHO (2016a): Framework of engagement with non-State actors. Geneva (Doc. WHA 69.10). http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_R10-en.pdf?ua=1

WHO (2016b): Source and distribution of funds 2014-2015. Geneva. http://extranet.who.int/programmebudget/Biennium2014/Contributor

WHO (2012): Summary of Records, 130th Session of the Executive Board. Geneva (Doc. EB/130/2012/REC/2).

WHO (2011a): Financing of the World Health Organization. Geneva (Doc. EBSS/2/INF.DOC/2). http://apps.who.int/gb/ebwha/pdf_files/EBSS/EBSS2_ID2-en.pdf

WHO (2011b): The future of financing for WHO. Geneva (Doc. A 64/4). http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_4-en.pdf

WHO (2011c): WHO reforms for a healthy future. Geneva (Doc. EBSS/2/2) http://apps.who.int/gb/ebwha/pdf_files/EBSS/EBSS2_2-en.pdf

K M Gopakumar is Legal Advisor and Senior Researcher with the Third World Network (TWN).

22 WHO (2018), p. 9.