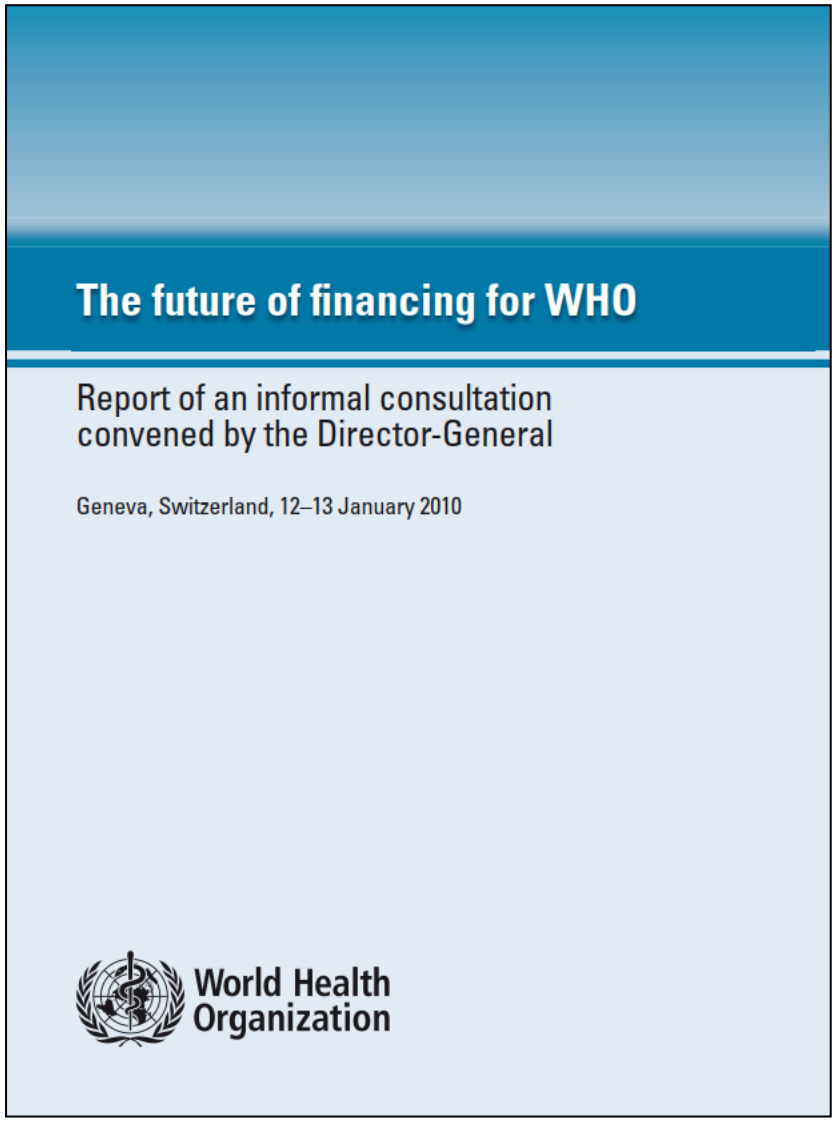
WHO Financing: A Global Public Good?

Remco van de Pas

Geneva, 19 January 2018

«WHO Governance: The conversation continious»

http://g2h2.org/wp-content/uploads/2018/01/Civil-Society-meetings-January-2018-programme.pdf



- Priorities vis-a-vis core business and value-added
- Fragmentation of international health financing
- System-wide problems across UN organisations
- Partnerships are key
- Financing: not more but better
- Less than 20% AC: predictability and flexibility is needed
- More pooled funding – preferably at country level

The Delhi Statement (2011)

Time to Untie the Knots:
the WHO Reform and the Need for Democratizing Global Health

- Right to Health must be central to GHG
- Policy coherence with non-health regimes
- WHO clearly defines its stakeholders
- Taxation key policy instrument welfare
- MS increase their financial contributions to WHO
- Focus on transparent, accountable, participatory mechanisms in GHG

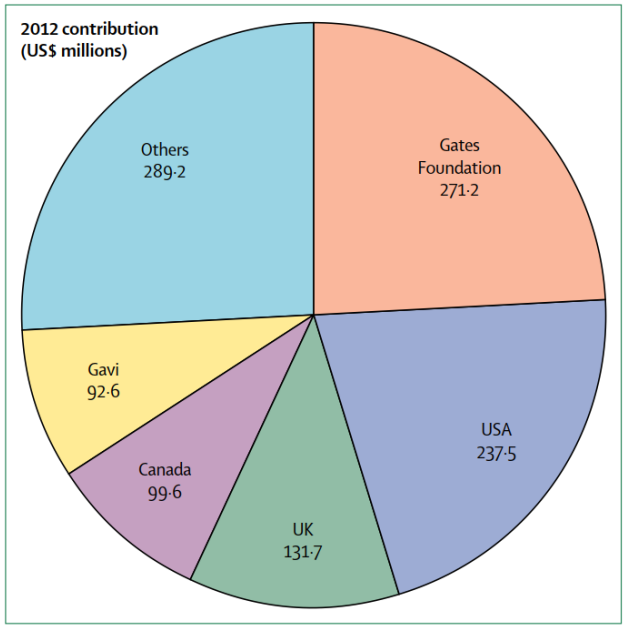


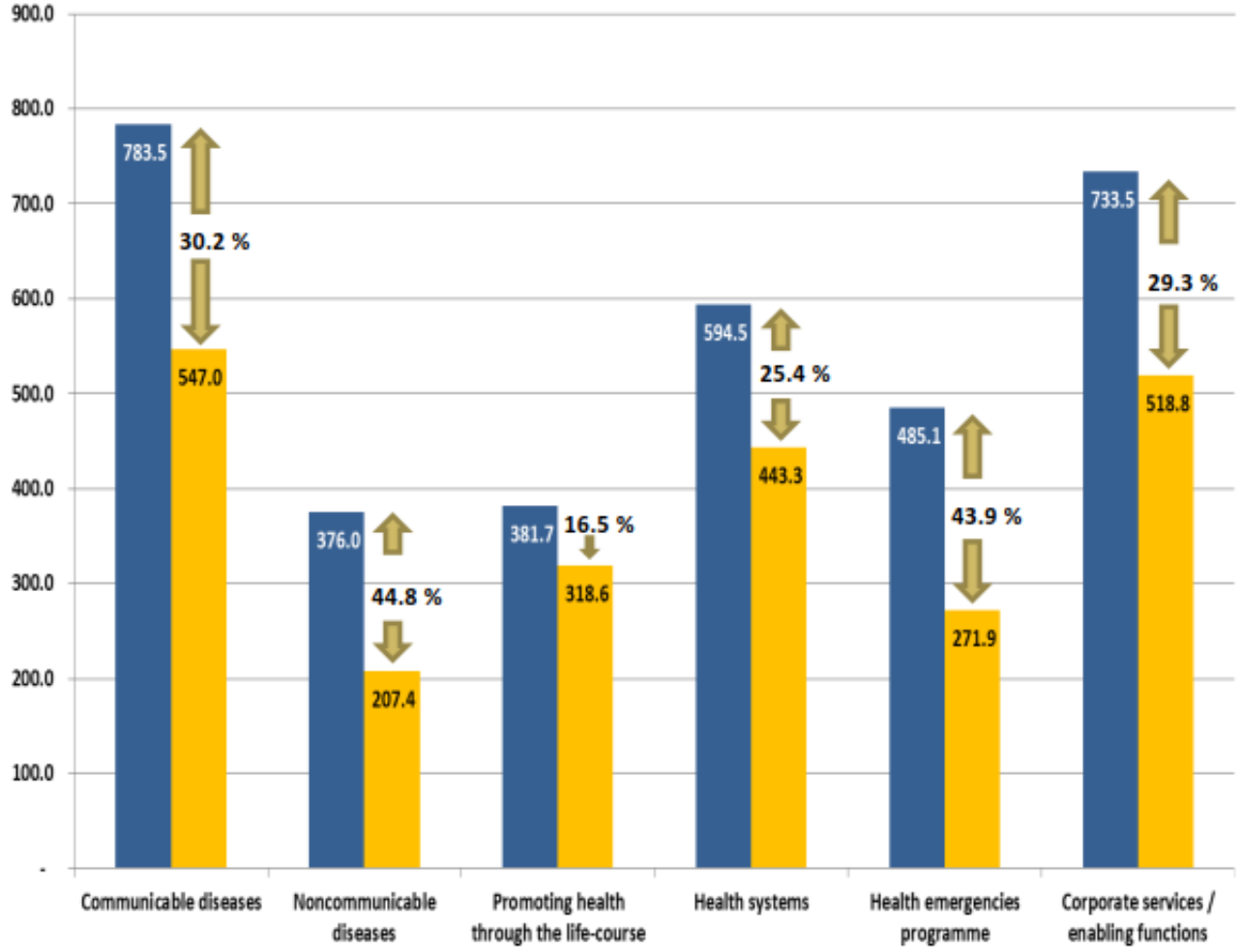
Figure 2: **Main contributors to the WHO in 2012**
Data from Institute for Health Metrics and Evaluation.[2]

"Trojan multilateralism"

covertly introducing bilateral goals and interests into multilateral institutions. These overlap with vertical initiatives and have the potential to corrode multilateralism.

(Sridhar & Woods, 2013)

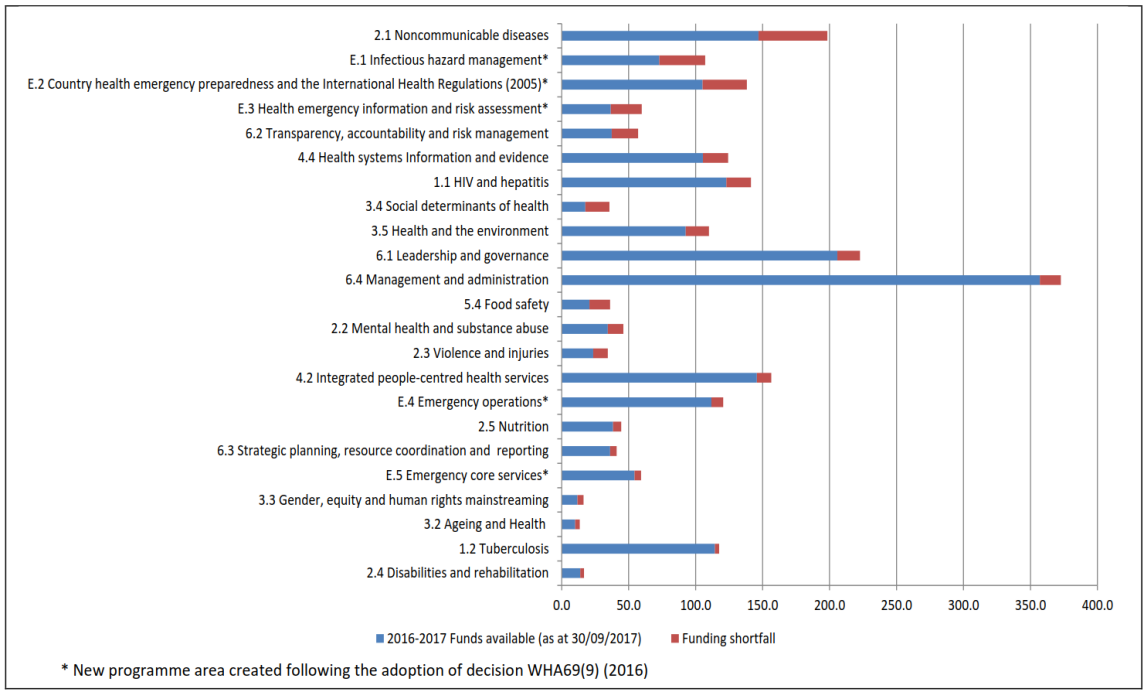
2016 – 2017 Q3 Base Funding Situation by Category (US$m)



- Largest technical area gaps in Noncommunicable diseases (44.8 %) and Health emergencies programme (43.9 %)
- Donor interest in other Categories increasing with time but not yet keeping pace with needs
- Decrease in flexible funds increases vulnerability to imbalances when donor funds are earmarked

Programme budget 2016–2017				
Components	Approved	Revised	Available financing (as at 30 September 2017)	Projected implementation
Base	3194	3354	3272	2614[a]
Polio, outbreak and crisis response, special programmes	1191	1191	2754	1818
Total	**4385**	**4545**	**6026**	**4432**

Fig. 1. Programme areas facing financial shortfalls (as at 30 September 2017) (US$ million)[1]



* New programme area created following the adoption of decision WHA69(9) (2016)

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Financing of the programme budget: EBPBAC27/3 (2018)

- The overall projected financing of the Programme budget is US$ 6026 million, comprising US$ 3272 million for the base programmes and US$ 2754 million for polio and outbreak and crisis response . This financing is made up of US$ 5097 million in voluntary contributions (**85% of total),** and US$ 929 million in assessed contributions (**15% of total**). “
- “Less positively, it is currently estimated that the level of core voluntary contributions will reduce further, which **negatively impacts the Organization’s flexibility i**n the context of the forthcoming work on reprioritization. “
- “The WHO financing dialogue has been recognized as an innovation which has gone some way to improving alignment of specified voluntary contributions and improved predictability.”
- “**It takes two to tango”** – WHO doesn’t need more money overall. It needs quality money . WHO had over 3000 separate grants annually. “If situation persists, then change can not happen.” (Dr. Tedros, closing remarks, WHO EBSS 4, 2017)

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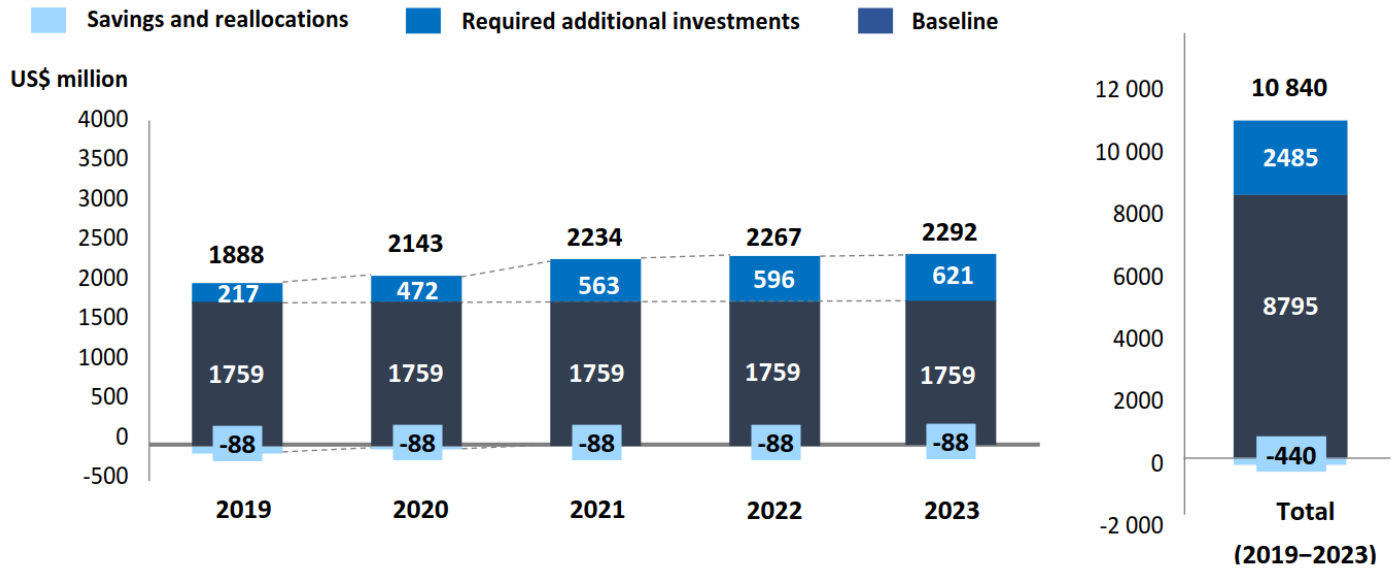
Fig. GPW 13 financial estimate for the base segment: US$ 10.8 billion over the five-year period



- Additional investments required: on the basis of the modelling, the **total additional investments** needed over the five-year period amount to US$ 2485 million.
- Savings through **economy and efficiency:** some of the required net additional investment will be offset, by as much as 5%, by means of internal savings, as much as US$ 440 million.
- Pandemics and the many other **health threats**….. cost the world far more than the **additional investments** argued for in this document. Thus, GPW 13 presents a unique **return on investment**. (EB142/3 Add.2 , 2018)

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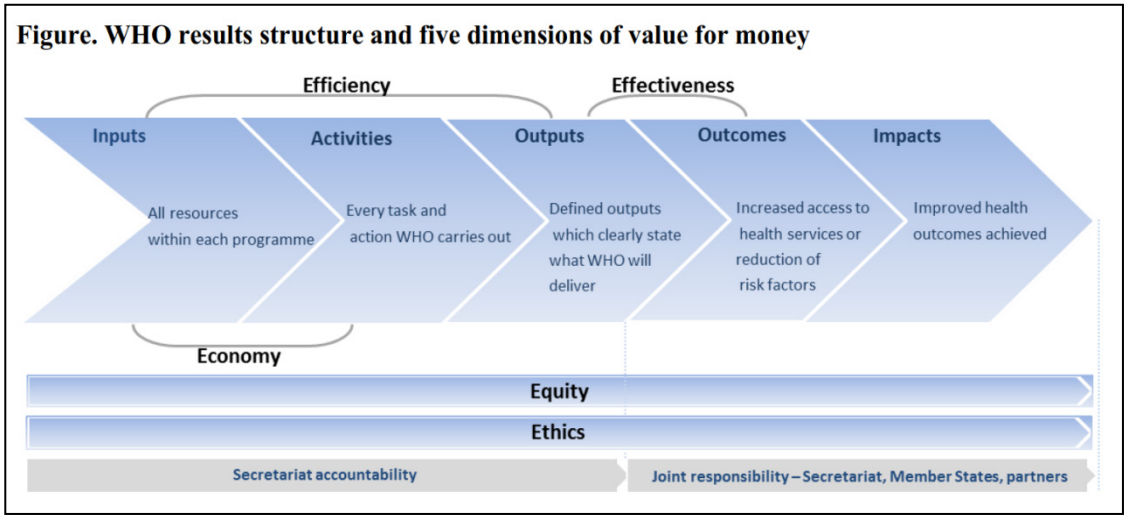
WHO & New Public Management: Value for Money or heading for a Cruel Disappointment?



"In order to help the Organization to devise the model for **its value-for-money approach,** the Secretariat sought to map relevant current practice in other multilateral organizations…. All took into account efficiency and effectiveness, but there was **no evidence anywhere of an ethics consideration.** Considerations of economy and equity varied."

(EB142/7 Rev.1, 2018)

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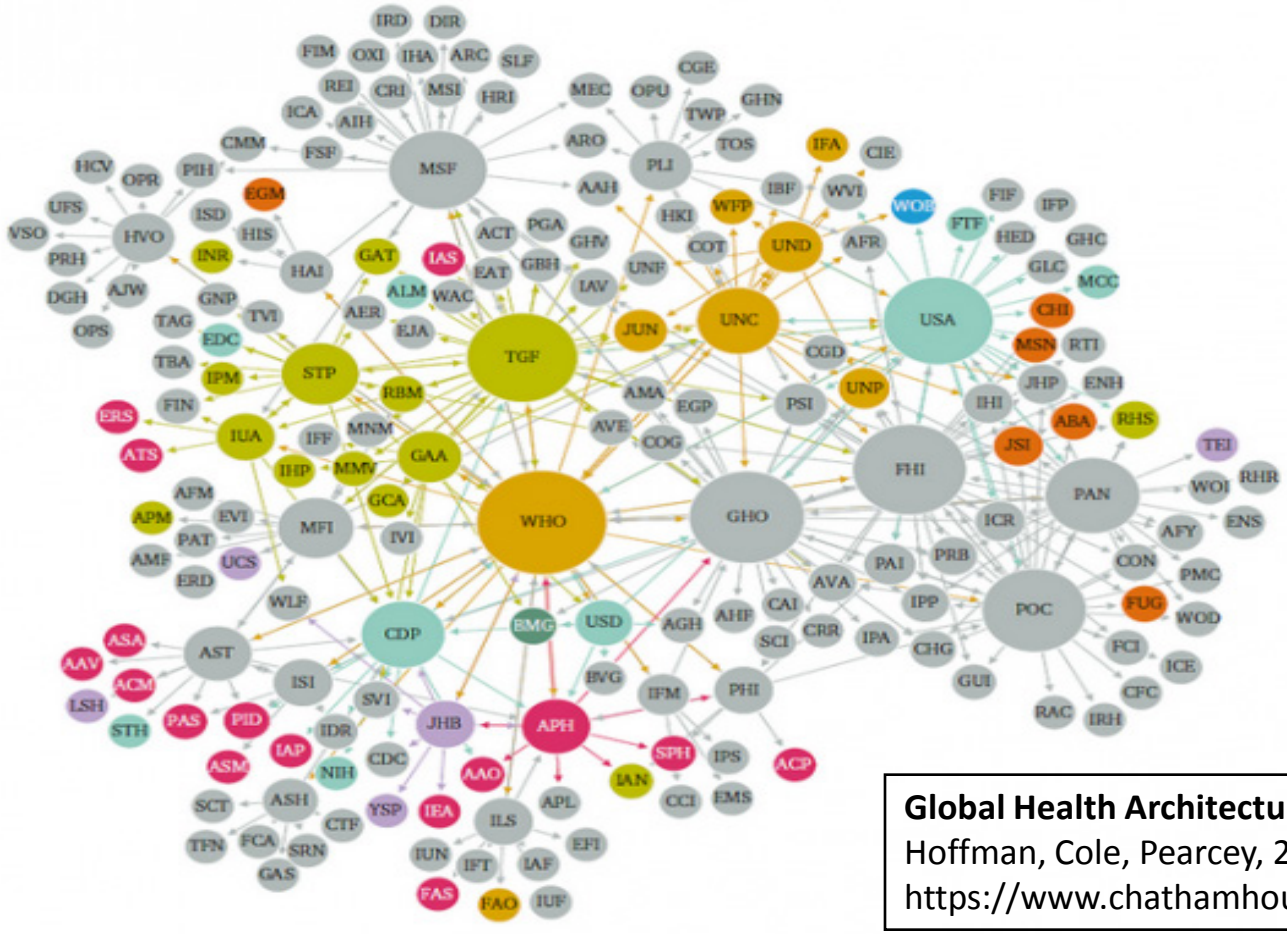
Mapping Global Health Actors



Global Health Architecture, Chatham House, Hoffman, Cole, Pearcey, 2015
https://www.chathamhouse.org

Node size is ranked by degree; node colour is partitioned by type of actor; and edges are coloured by source node.
*See Appendix A for key to actor codes.

- Global civil society organizations and NGOs
- Professional associations
- Public-private partnerships
- National governments AAV
- UN system and intergovernmental
- Private industry
- Academic institutions
- Philanthropic organizations
- Multilateral development banks

Functions of the key actors?

1. Leadership and stewardship

   a) Convening for negotiation and consensus building
   b) Consensus building on policy
   c) Cross-sectoral advocacy
   d) Agency for the dispossessed
   e) Advocating for health[5]

2. Ensuring provision of global public goods

   a) Discovery, development and delivery of new health tools
   b) Implementation research, extended cost-effectiveness analyses, research priority-setting tools and survey methodologies
   c) Knowledge generation and sharing
   d) Sharing of intellectual property
   e) Harmonized norms, standards and guidelines
   f) Market shaping

3. Management of externalities

   a) Responding to global threats
   b) Surveillance and information sharing

4. Direct country assistance

   a) Technical cooperation at national level
   b) Development assistance for health
   c) Emergency humanitarian assistance

Global Health Architecture,
Chatham House,
Hoffman, Cole, Pearcey, 2015
https://www.chathamhouse.org

Financial measures: Addis Ababa Conference on Financing for Development July 2015

Domestic resource mobilization

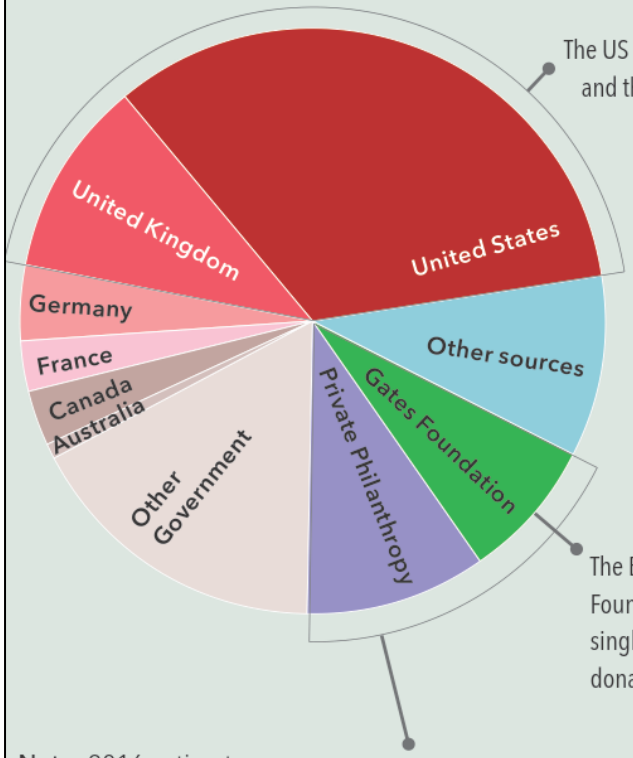
Government: countries agreed to measures aimed at widening the revenue base, improving tax collection, and combatting tax evasion, and illicit financial flows.

Private Sector: Importance of matching private investment with Sustainable development incentives and disincentives through public policies and regulatory frameworks

Development Assistance: countries reaffirmed commitments for official development assistance (e.g. existing promises of 0.7% GNI, 15-20% to least developed countries and fragile states). ODA leverages further investment and innovative finance mechanisms

(adopted from Evans, 2015)

DAH by source of funding, 2016



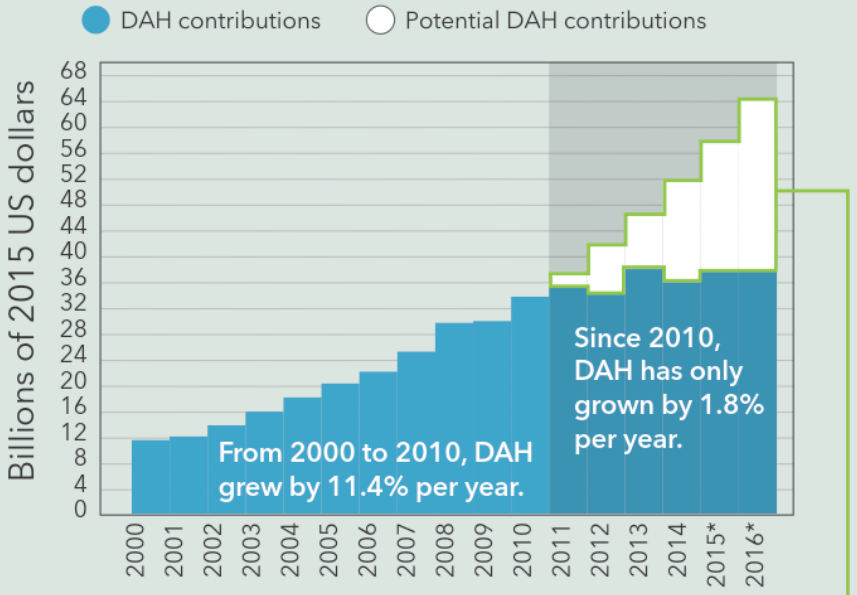
The US gave **33.9% of total DAH**, and the UK gave **10.9%**.

The Bill & Melinda Gates Foundation was the largest single private contributor, donating **7.8% of total DAH**.

DAH from private philanthropies, including the Gates Foundation, amounted to **17.8% of total DAH**.

Note: 2016 estimates are preliminary. DAH includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries.

Total DAH, 2000–2016, observed versus potential



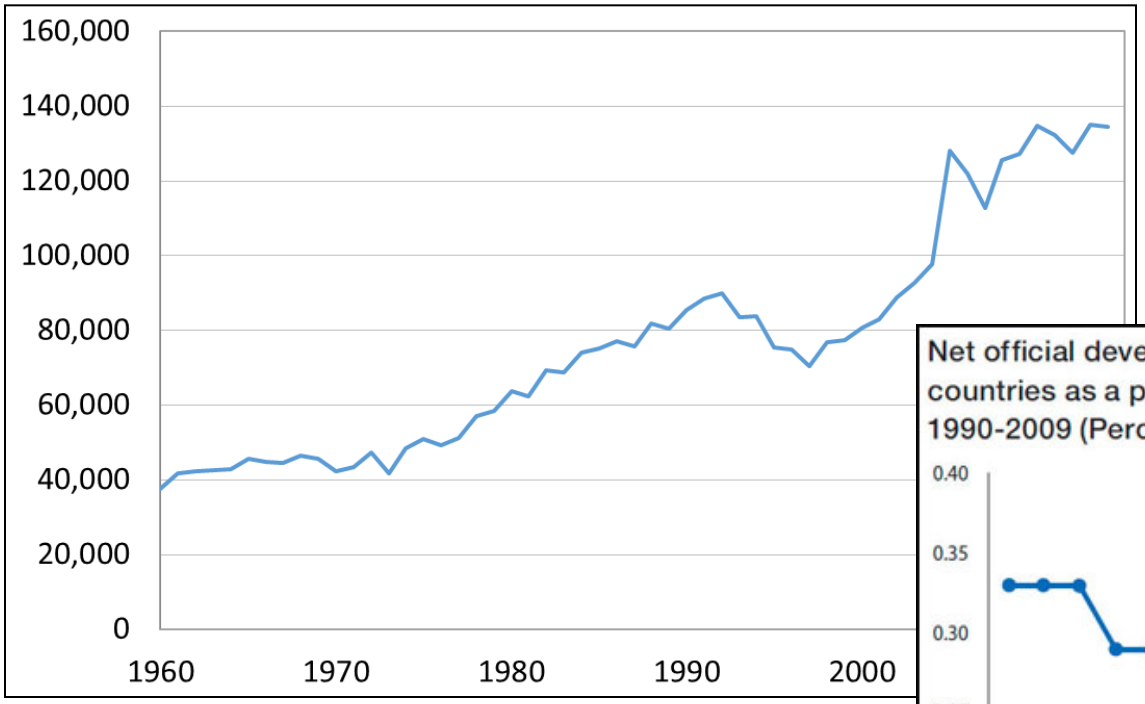
If the 11.4% growth rate in DAH from 2000 to 2010 had continued from 2010 and 2016, an additional **$82 billion** would have been devoted to improving health, over the last six years.

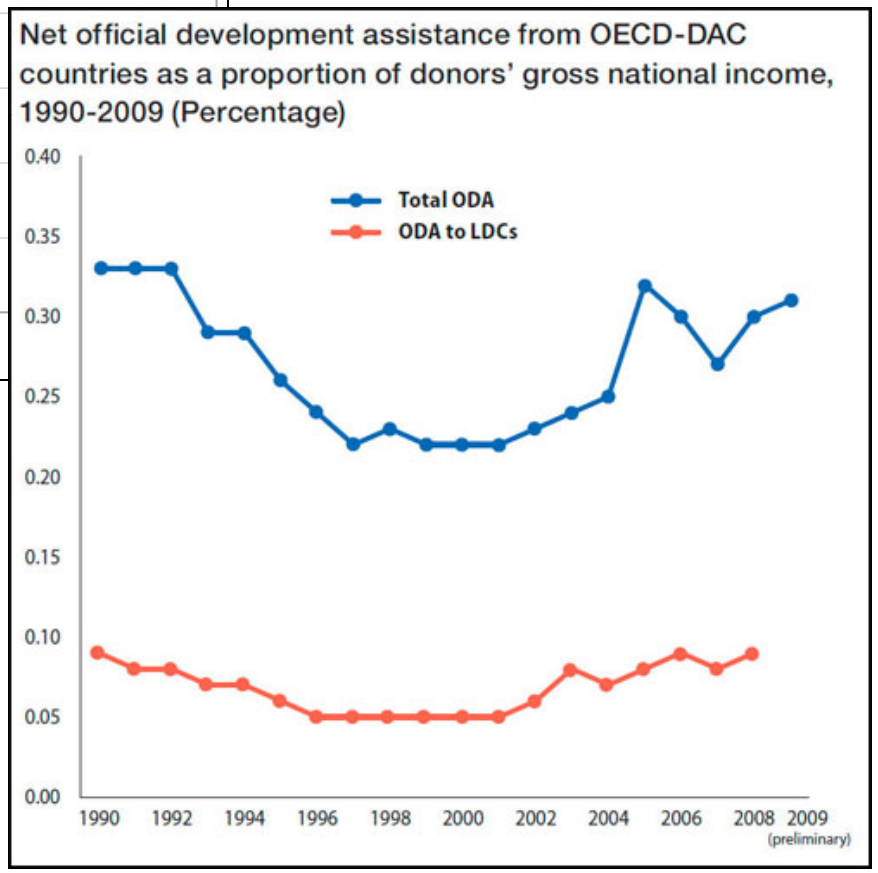
*2015 and 2016 are preliminary estimates.

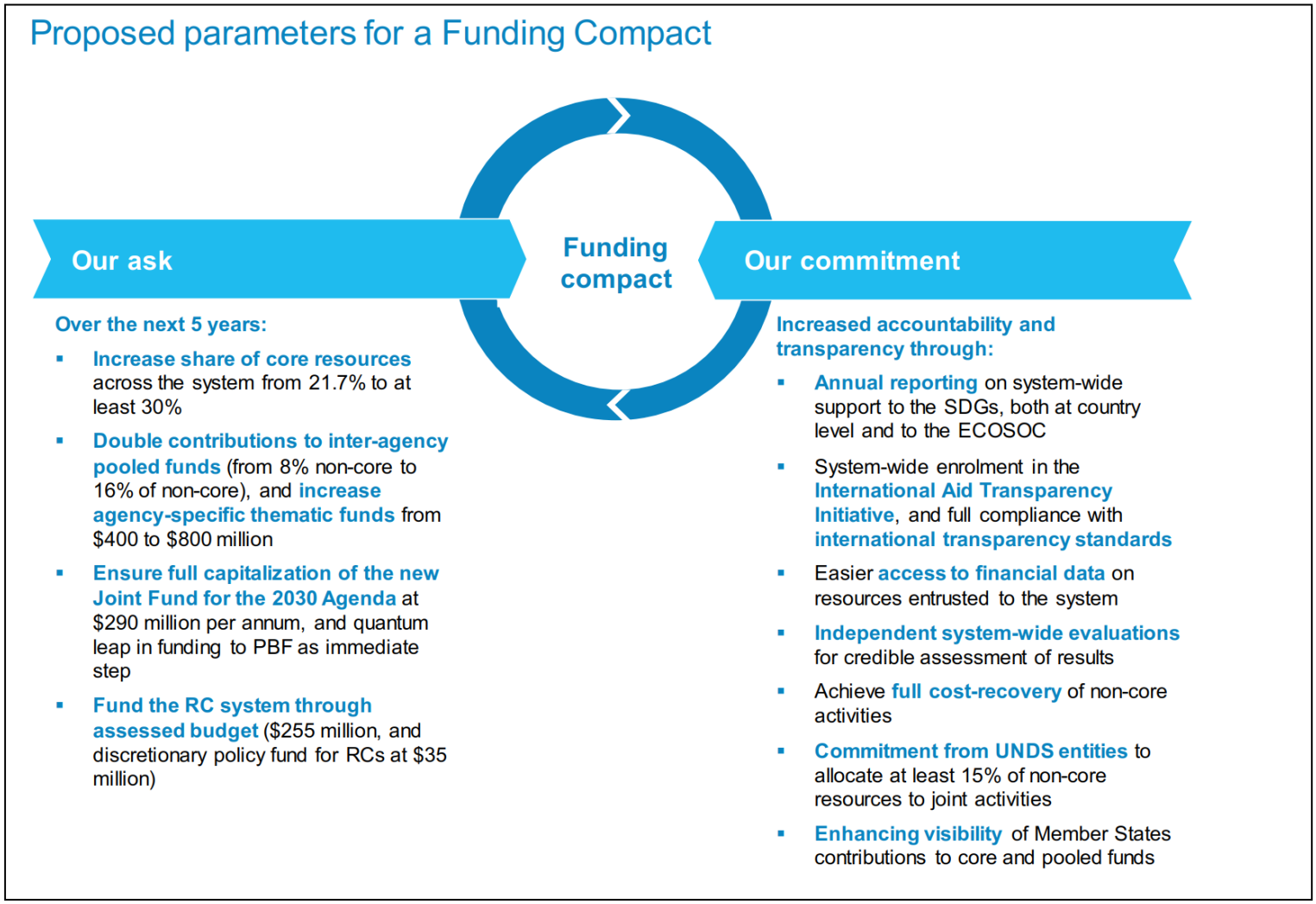
Note: Continued growth scenario for DAH is modeled from 2011 to 2016, as based on the average annual percent increase from 2000 to 2010. The difference between DAH disbursed and DAH with continued growth is captured by the white boxes and the funding levels reported therein.

(Institute of Health Metrics & Evaluation, 2017)

Official Development Assistance (OECD/DAC)







UNSG: Repositioning the United Nations development system to deliver on the 2030 Agenda: our promise for dignity, prosperity and peace on a healthy planet (2017)

"The CIS analysis found a **major correlation** between a government donor preference for **earmarked funding** and a belief that the **private sector is more efficient** than the public – not only in developing countries but also at home. "Specifically the **market orientation** of donors' economies, such as their stance on outsourcing public service delivery domestically, positively correlates with the degree of **'bypassing' recipient governments** in weakly-governed countries."

(Global Policy Watch, Jan 2018)

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Financing Global Public Goods for Health : Mechanisms

Funding for the production of GPGH may be achieved in four main ways.
1. Voluntary contributions - most straightforward option, but prone to free-rider problem since each country has an incentive to minimise its contribution.

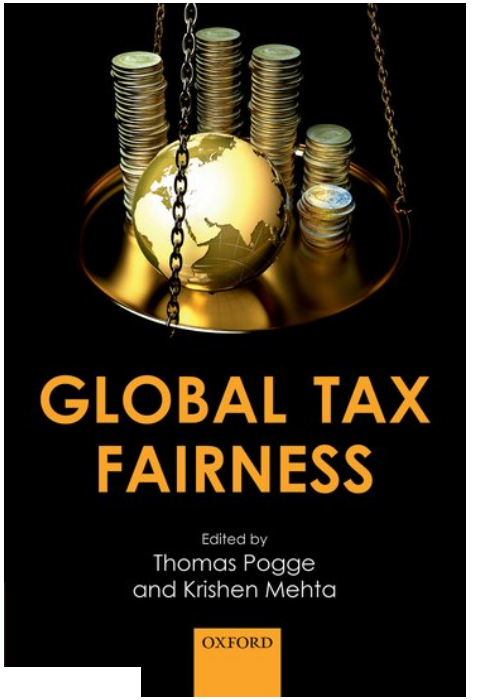
!! 2. Ear-marked national taxes coordinated between countries - achievement of health improvements rests on the discouragement of particular activities, such as tobacco consumption or pollution.

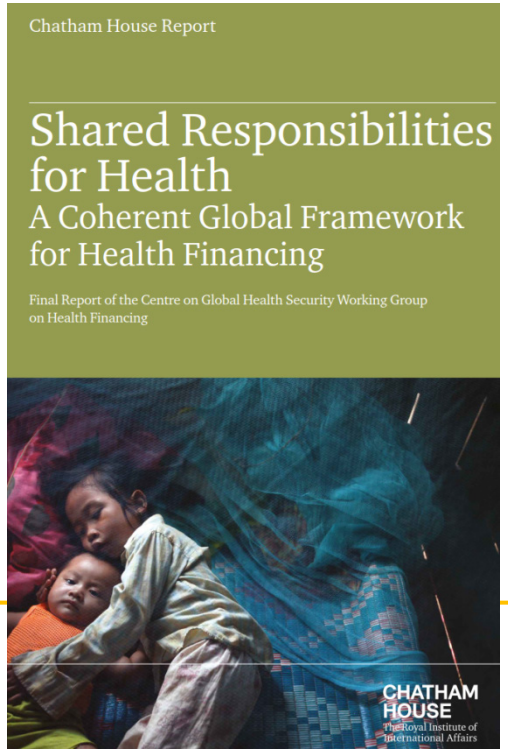
!! 3. Taxes imposed and collected at the global level, such as the 'Tobin tax'. However, wide variations in estimates of the amount of, and the competing uses for, the proceeds, make this likely to be resisted by some major developed countries.

4. Market-based mechanisms, such as trading of emission rights, can only be used where there is something to trade, and they do not generate additional resources unless transactions are taxed.

Woodward & Smith. Global Public Goods and Health: concepts and issues.(2003)
http://www.who.int/trade/distance_learning/gpgh/gpgh1/en/index13.html

Financing GPGH such as WHO's functions : moving forward





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