The Changing Role of Health-Oriented International Organizations and Nongovernmental Organizations DRAFT July 2014

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1. Introduction

This contribution analyzes the changing policy directions and activities of international organizations (IOs), Public-Private Partnerships (PPPs) and nongovernmental organizations (NGOs) in health care and health policy-making (or “health-oriented IOs, PPPs and NGOs”) in low-income and middle-income countries. It aims to contribute to the growing body of literature about international governance in health and health care. IOs serve different functions as independent actors in the global policy arena, tools for national governments to realize certain policy goals, and platforms for debate (Hurds 2011). Health-oriented IOs, PPPs and NGOs support activities to alleviate poverty and improve the health in poor countries. They realize their goals in different ways, acting as funding agencies, policy advisors, health care providers and managers, or advocates on behalf of others. Large IOs provide technical assistance, policy advice, and sometimes funding as well. The functions of large NGOs and public-private partnerships (PPPs) are similar to those of the IOs, but with a greater emphasis on financing of health care goods and services than on actual program management. NGOs often advocate specific causes that—in their eyes—do not receive enough attention from governments (e.g., HIV/AIDS, women’s reproductive health, or research in “orphan diseases” for which the pharmaceutical industry has no or little commercial interest). They raise funds for specific (and often local) activities, project and programs to support particular communities or strengthen the health care systems (Davies 2010; Youde 2012).

The central questions of this paper are: “How can we assess the changing roles and activities of health-oriented IOs, PPPs and NGOs? What do we know about their results? What can we expect in the future?” We will address these questions by analyzing the stated policy goals and activities of selected health-oriented IOs, PPPs and NGOs, present evidence of the shift in positions and discuss critical commentary about their roles. Our research draws from academic literature, interviews with experts and internal documents of the organizations. Before doing so, we draw the attention to two methodological issues: the position of IOs, PPPs and NGOs in (international and national) health policy-making, and the lack of generally accepted common criteria to assess the successes and failures of those organizations.

Health policy is generally considered as a core government responsibility, but there are many more parties or stakeholders active in the health policy arena: patients and the general population as tax payers or insured; physicians, hospitals and other health care the providers; public and private health insurance agencies as third payers for medical care; and governments (Alford 1974). Other groups play an important role, too: the media, academics and a wide array of IOs, PPPs and NGOs.¹ The latter three are the main focus of this paper, in particular those that
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state as their main mission to improve the health of (low-income) populations of low-income countries.

IOs, global PPPs and NGOs occupy space between governments and markets (Kaul 2006; Leonard 2002). While IOs (by statute) work with governments, smaller NGOs often seek direct ties with the local communities they support. IOs, PPPs and NGOs are thus located both outside and within the realm of national (health) policy-making. All their activities ultimately affect public policy-making one way or another. As we will show, the activities of IOs, PPPs and NGOs increasingly overlap and compete with government agencies and other organizations in donor and recipient countries.

A second preliminary point is the lack of common analytical framework to assess the changing positions of IOs, PPPs and NGOs. Despite the steady rise in the numbers and prominence of NGOs, there is lack of (empirical) knowledge about their functioning in the international policy arena (Hafner-Burton and Gartzke 2008; Lewis and Opoku 2006). Until the late 1990s, most research on IOs seemed to focus on organizational issues (Brown et al. 2006). The dramatic rise of non-state actors (including large multinational firms, international NGOs, guerrilla groups and criminal gangs) led to erosion of state power (Willetts 2001). Governments became but one of the groups of actors in international relations, often not even the most powerful ones. The health policy arena is densely populated by a wide variety of organized interests. Understanding (government) policy-making therefore requires understanding of those bureaucratic and political realities. The World Bank or WHO, for example, are very large bureaucracies (Ebrahim and Hertz 2007), and so are some of the large NGOs with large staff and several office locations across the globe. Most studies of the IOs implicitly assume that they are unified and rational actors, ignoring that such large bodies are internally fragmented and have to bargain with others in dealing with internal and internal pressures to change directions. Tracing back to earlier theories of organizational behavior of private firms, Allison (1971) argues that in fact, governments consist of many different departments and quasi-independent administrative bodies, each with their own standard operational procedures and policy goals. Allison’s warnings also apply to non-governmental organizations. As a broader framework, we assert, the classic analytical instruments for understanding the shaping and outcome of public policy: ideas, interests and institutions (Klein and Marmor 2009) thus apply well to the changing positions of the IOs, PPPs and NGOs.

Some scholars applied the “principal-agent” theory to study the origins of IOs. They basically assume that nations (namely, national entities that act as unified rational actors) decide to participate in creating a new IO or join an existing one when the benefits of doing so (e.g. division of labor, policy externalities, efficient decision-making or dispute, activities that are hard or very expensive for an individual nation to perform) exceed the costs of joining or remaining a member (Hawkins, Lake et al. 2003). A government can decide to end membership when it faces “agency problems”, i.e. it feels the organization is drifting away too far from its original mandate or its interests are not served well. But it can be costly (politically speaking) to “exit”, and most member states remain members most of the time. But, as we will show, “partial exits” are more common as countries increasingly prefer to channel part of their aid via NGOs and PPPs instead of abandoning the IOs altogether.
Other theories focus on changing power relations. For example, Matthews (1997) observes a redistribution of power among states, markets and civil society in the post-Cold War era. In particular, the widening access to the Internet gave more power to NGOs and other smaller groups, undermining state power and challenging the very concept of states as the major actors in international relations. Obviously larger states have more power than smaller ones to influence the policy directions of IOs (Stone 2011). Analyzing the influence of the United States in the International Monetary Fund (IMF) and other international financial IOs, Woods (2003) concludes that even as the major shareholder the U.S. cannot impose its will all the time. Some experts consider IOs as effective carriers of “soft” power (Caroll and Kaye 2013). Barnett and Duval (2005), as another example of power theories, distinguish four forms of power in global governance relations: compulsory (e.g. direct influence of nation over another one); institutional (indirect influence via international organizations); structural (the capacity to enforce constitutional change) and productive (the power to orient society toward certain activities or cultural orientations). It appears that the institutional and productive powers are most relevant for the study of IOs and NGOs.

The second section of this contribution presents a brief overview of the origins, current activities and changing roles of the major health-oriented IOs: the World Health Organization (WHO), the World Bank (IRBD) and the Organization for Economic Cooperation and Development (OECD) (even while the latter two are not uniquely or even predominantly oriented on health and health care, we include those in this study as they play a major role in the field). Section three discusses the Global Fund and GAVI, and section four focuses on Doctors Without Borders (MSF) and the Bill and Melinda Gates Foundation. Section five discusses the experience with foreign aid of a small African country, Malawi. The sixth section presents a framework to compare IOs, PPPs and NGOs. We present our conclusions as well as expectations for the future in the last section.

The position of health-oriented organizations changed in the 1980s and 1990s in several important ways (Davies 2010; Youde 2012). The number of NGOs active in health and health care (mostly relatively small, but a few very large ones, see section 3 below) grew dramatically, and several existing IOs expanded their activities into this field, in particular the World Bank and the OECD. As a separate circuit of exchange, moreover, informal elite groups increasingly serve as platform for debate for world leaders, (self-acclaimed) world thinkers and others, and issues of health are commonly on the agenda. For example, at the World Economic Forum world leaders meet (and rub shoulders) with pop stars and other celebrity to discuss social and economic issues of international importance. We conclude that the changing positions of the health-oriented organizations discussed in this paper resulted in growing overlap in activity, fragmentation of health care services, and contradictory directions of policy advice. We also conclude that due to a lack of comparative data or a common analytical framework, it is hard to compare their roles, activities and results. We present a simple matrix of their goals, policy instruments, modes of interest representation, evaluation and assessment methods and strengths and weaknesses to allow for a more systematic comparison between the IOs and NGOs, and conclude with some expectations about their future.
2 Health-Oriented International Organizations: United Nations, World Health Organization, World Bank and OECD

International organizations serve a wide variety of functions. IOs collect statistical data, publish annual reports and analytical studies, channel and coordinate development aid to low- and middle-income countries, and monitor results. Their statistical databases and reports serve as input for national policy-making and international comparative research. Their annual meetings and standing committees serve as platforms for discussion where heads of governments and national experts meet to exchange experiences and discuss future policy directions. IOs provide governments with advice or (financial) support for fiscal, economic and social policies. Brief, their activities aim to support and change national policy-making. This section discusses the major health-oriented IOs: some UN agencies, the WHO, IBRD and OECD. Before discussing those IOs, table 1 (below) presents core data on external and domestic health care funding.

TO BE ADDED: Table 1 Domestic spending and foreign aid for health and health care in selected low- and middle-income countries, 1990-2010  (data on: population; income per person; PPP income; total net development aid; total health expenditure (% GDP, dollar amounts); share of foreign aid in THE; public-private spending; core health status data; World; Low income countries; Middle Income countries; High Income countries (and perhaps add some examples of low and middle income countries). Source: World Bank; WHO, IHME in Seattle

The above data illustrate the strong correlation between health, health care spending, and the share of health care spending from collective sources. The higher the income, in general, the higher the share of national income dedicated to health care and the lower the share from individual patients and their family. Reversely, low-income countries spend (much) less on health and health care, both as a share of their income and in average dollar amounts per person. That low level of spending is not due to better health (Schieber and Maedo 1999). The poorest population groups in the poorest countries spend the most out of pocket for medical care. Moreover, there is wide variation in external funding that is not explained by income level or health needs of the recipient countries (IHMI report 2013). And importantly, IOs, PPPs and NGOs may be substantial, but in the vast majority of low-income and middle-income nations, they only play a role in the margin in financing health care as most health expenditures are born by families, not by national governments or foreign organizations.

United Nations

The United Nations (UN), established after World War I, is the largest group of worldwide IOs. Almost all the countries of the world are member. The UN family includes political bodies (e.g., the Security Council), economic and social committees, and a wide range of specialized agencies, special programs, as well as the so-called Bretton Woods organizations (see the organizational chart of the UN in the Appendix). Until the 1970s, most IOs worked under the aegis of the UN (following the principal-agent theory, most countries in the world clearly
considered the benefits of UN membership worth the costs), and there was largely agreement about their roles: the Food and Agriculture Organization (FAO) dealt with food and agriculture, for example, the World Bank with (economic) development and poverty, the International Monetary Fund (IMF) acted as a central bank in the international central banking system, and the WHO was the leading agency for issues of (public) health. That is not to say that the borderlines between IOs were always clear cut or undisputed. For example, not only the WHO but many other (UN) organizations were—and are--involved, one way or another, in health care in low-income countries, for example the UN Children’s Fund (UNICEF), the UN Development Program (UNDP), or the Joint UN Programme on HIV/AIDS (UNAIDS). Moreover, there are “spill-overs” from one policy domain to another one. For example, fiscal policy recommended by the IMF or World Bank to reduce public debt often creates pressures to reduce public spending for health or education.

**The World Health Organization**

The WHO, created in 1948 as the major organization for health and health care issues, aims to improve the health of the world’s population. Its original mandate focused on issues of public health, for example control of infectious disease, vaccine development, and “directing and coordinating body on international health work” (WHO 2013). WHO headquarters are in Geneva. It has 6 regional offices and country offices across the world. The formal decision-making power over policy directions rests with the World Health Assembly (WHA) that consists of the Health Ministers of all member states. The WHA meets each year in Geneva.

Over time, the WHO broadened its ambitions and scope of activities. At the Alma Ata Conference of 1978, for example, it presented the report “Health for All in the Year 2000” (“HfA 2000”). The report stated that by the year 2000, everyone should have achieved the level of health needed to lead a socially and economically productive life. The report pointed to the major ‘determinants’ of health (smoking, drinking and other ‘life style’ factors; genetic disposition; working and living environment; and access to health care services). It saw “primary care” as the main vehicle for health improvement, and defined health as “complete physical, mental and social wellbeing” (Yamey 2002). By the late 1980s, however, the WHO had come increasingly under fire. Critics pointed to the lack of success of the primary care strategy and the weak leadership of the organization (Godlee 1994; Yamey 2002). It became clear that the ambitious Health for All goals had failed to materialize--even while all WHO members had signed the HfA document.

Gro Brundtland, the former Prime Minister of Norway, took over as Director-General of the WHO in 1998 (leaving in 2003). Brundtland took steps to improve the organization and repair its damaged image. She framed new (or renewed) global WHO activities dealing with malaria, tuberculosis, HIV/AIDS, safe blood, cancer, cardiovascular disease and diabetes, maternal health, food safety, and mental health, and launched the Framework Treaty against Tobacco in 2003 and the Roll Back Malaria Initiative. The long and ambitious list also included improvement of health systems (an interesting example of “mission creep” that caused increasing overlap between WHO, IBRD and OECD). The campaigns helped to place health as an
important policy issue on the international agenda. Still critics argued that the reforms did little to repair the image of the organization or improve its governance but if anything, increased central control within the WHO (Yamey 2002).

The much-discussed and much-criticized 2000 World Health Report (WHR 2000) ranked all the health care systems of the world. It applied disability-adjusted life years (DALYs) to measure the “global burden of disease,” and identified crucial success factors of health care systems (e.g., efficiency, quality and fairness in distribution of the financial burden). The report came under fire because of its contested methodology, lack of data (sometimes compensated by rough and subjective estimates of WHO staff), and assumptions about the value of life. Other criticism concerned the overly high ambitions, lack of peer review, inadequate consultations with stakeholders, and secrecy of the production of the report (Williams 2001). Brief, the high ambitions to present a worldwide ranking of health systems became a public relations nightmare, and WHO never duplicated the effort. Meanwhile, the regional WHO offices mostly continued to “do their own thing”. For example, the European WHO office in Copenhagen started the series Health Care Systems in Transition (HiTs) of over 50 countries in Europe and beyond (Marmor and Okma …).

In the last two decades, WHO’s finance has been in permanent crisis. As regular contributions did not keep up with expenses, WHO had to seek voluntary contributions—that by 2012 covered over three quarters of the total budget. With that specific funding came strings about the way and direction WHO should spend the money (in fact, a form of “partial exit”). This precarious financial position prompted renewed efforts to streamline the organization and reduce bureaucracy (Working paper, Centre on Global Health Security Working Group). WHO also faced mounting competition of other organizations. The international landscape had changed, with growing interest in issues of health by increasing numbers of new and existing organizations. For example, health became an agenda item for the G8—traditionally the forum for fiscal and economic policy debate. Other IOs (especially the IBRD) and newly created PPPs challenged the leading position of the WHO (Yamey 2002). GAVI, the Global Fund and the Bill and Melinda Gates Foundation became major players in the field. Many smaller NGOs, as shown below, became active in the health domain as well.

The World Bank

The World Bank (in full: International Bank for Reconstruction and Development, IBRD) consists of five agencies: International Bank for Reconstruction and Development (IRBD—sometimes used to indicate the entire World Bank Group), International Development Agency (IDA), International Finance Corporation (IFC), Multilateral Investment Guarantee Agency (MIGA), and International Centre for Settlement of Investment Disputes (ICSID). The Bank’s mission is to reduce poverty in the world and promote sustainable growth. IBRD loans (with market-level interest rates) mostly benefit middle-income countries, whereas lower-income nations are eligible for soft loans and grants from IDA. IFC supports private investment in low- and middle-income countries, on the condition that private investors join the project. MIGA
encourages private investment by guaranteeing (part of) investments. ICSID helps to mediate investment disputes (www_IBRD.org).

Created in 1944, the World Bank initially targeted its lending to Western European nations for the post-war reconstruction of physical infrastructure. Two decades later, its focus shifted to poor (or “underdeveloped”) countries, widening the lending scope to other sectors. By the late 1980s, it had become a major lender for social policies. After the financial crisis of Mexico of 1982, the Bank initiated “structural adjustment lending” in close collaboration with the IMF. With those shifts, the Bank gained an important voice in the shaping of social policies, in particular health policy. By 2012, total IBRD lending (new commitments) was almost US$53 billion: IBRD $20 billion; IDA $14.7 billion; IFC over $15 billion and MIGA $2.3 billion. (IBRD Annual Report 2012). Health-oriented lending of the World Bank group increased form US$2.5 to US$14 billion between 1995 and 2005 (McCoy et al 2009).

By the late 1990s, IBRD had become the major lender in this field—without a clear mandate or reflection whether it would be the best organization to take the lead role (Abbassi 1999). It replaced WHO as the major influence behind health policy in poor countries—if only because of its greater funding power (Abbassi 1999). Critics argued that the Bank had become an “industrial mastodont,” failing to adjust its old business model and outdated resident board, or to properly acknowledge the new players in the world economy: China, India and Brazil (e.g., by giving those nations greater voting power on the board) (Forbes 2011). The institution was also slow in dealing with issues of environment, discrimination and social exclusion. It failed to deliver on its promise to alleviate poverty in the world, but contributed to the rising debt burden of poor countries. The Bank’s agenda reflected the dominant neo-liberal ideology of the U.S. and other major shareholders, other critics observed (Armada et al 2001). That orientation also spread to WHO and other IOs as well as NGOs, and translated in pressure to reduce social spending and privatize health care services. Reacting to those criticisms, the IBRD sought to soften its public image by focusing more on issues of poverty, governance, environment and social sectors.

The Organisation for Economic Development and Co-Operation

The Organisation for Economic Development and Co-Operation (OECD) in Paris provides analytical reports and advice on fiscal and social-economic policy (but no money) to its members. Membership is restricted to the richest countries of the world (30 in 2012). For over 50 years, OECD served as a think tank and a forum to discuss fiscal and social policies and development issues, and share information on good practices. It has been more flexible than other IOs and successful in actually implementing and distributing soft law principles (Caroll and Kay 2013). In the industrialized world, The OECD has been a strong actor, but it has been slow in including new major world players in its orientation like the BRIC countries (Verschaeve et al. 2011).
The OECD entered the health policy field in the late 1970s when it realized that health care had become a major public spending category. The OECD Health Database became the leading collection of statistical data on health, health care and health spending, and the most important source for international comparative research. The OECD also reported on international experience with health reforms (OECD 1992; 1992). By the mid-1990s, the organization had gained a leading role in analyzing and comparing health policies across the industrialized world.

Given OECD’s overall orientation of fiscal and economic matters, health was still a relatively minor part of its programs, largely funded by ad hoc, voluntary contributions by key member states. The US financed much of this work in the 1980s and 1990s, but in the early 2000s it grew dissatisfied with the OECD’s work on health care quality indicators, both the reliability and validity of the data used and the normative assumptions underlying the comparisons. As the US withdrew its voluntary funding, other key member states started to try and shape the health agenda more directly--at the expense of the permanent secretariat--by seconding researchers (often relatively junior) to the OECD. In the wake of this ‘partial exit’, the European Commission and key EU member states increased their funding to support the OECD Health Project. In this project, the OECD continued to expand its Health Database, collaborated with the WHO to create a worldwide statistical data collection, and published reports on the health care and health policies of individual countries. Whilst the OECD’s work on health over the last decade has broadly satisfied the concerns of its key EU members, it lost its preeminent position as the authoritative source internationally of comparative studies. In the early 2000s, OECD’s Board (consisting of ambassadors of all member states) decided to no longer prioritize international comparison in health policy. Others took over, both other IOs like the World Bank and the WHO (in particular the European office of the WHO in Copenhagen), PPPs and private NGOs and foundations (e.g. the Commonwealth Fund, the Kaiser Family Foundation or the Bertelsmann Foundation) as well as commercial firms.

Nevertheless, OECD continues to play an important ‘soft power’ agenda setting role in health care and health policy-making in its member states and beyond on issues like overall health system effectiveness, incentives for cost-control and clinical quality, the role of private health insurance, and remuneration for medical labor (Caroll and Kay 2013). Its work contributed to the definition of the nature and scale of health policy problems, as well as to various health care performance studies.

3. Public-private partnerships: the Global Fund and GAVI

Public-private partnerships (PPPs) gained momentum in international development policies in the early 21st century. Several donor countries considered the PPPs as effective and non-bureaucratic alternatives to existing IOs, promising fast and efficient disbursement. PPPs typically involve governments, IOs, NGOs, and the private sector (and sometimes affected communities) in program design and the allocation of available resources. The growth of PPPs
illustrated the legacy of the New Public Management stream that sought to reduce the role of the state and favor private sector involvement (Witz 2011). PPPs bring together different organizational cultures and management structures (Bovaird 2004). Some commentators consider PPPs as effective mechanisms because of the diversity and funding opportunities they bring to the table, including partners beyond the traditional IOs or NGOs. Some critics, however, point to the opaque decision-making procedures, weak evaluation mechanisms and accountability, and lack of evidence of the success of the new organizations (Blanks and Hulme 2012).

The Global Fund (source: 2012 paper Shelby Hockenberry)

The promise of rapid disbursement of (public) development money, with a seemingly non-bureaucratic administration popularized PPPs as vehicles for global policy issues (Sachs 2008). The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund, or GF), created in 2002, serves as a funding mechanism for global health concerns.

GF operates primarily as a financial instrument, not an implementing entity. It creates partnerships with public and private organizations, ordnates with existing regional and national programs, and solicits grant applications from a wide variety of health and community partnerships. Its programs are based on national plans and priorities. Recipients of the grants are states, foundations, intergovernmental organizations, NGOs and private business. The Fund aims to balance its grant programs over regions, diseases, and interventions, both for prevention and treatment. It provides financial support and leverage for additional resources, evaluates proposals through an independent review process, and seeks to operate with transparency and accountability (Global Fund 2007). The GF supports interventions that have shown to work (‘best practices’) and that can be scaled up to reach affected populations, in particular people affected by HIV/AIDS, tuberculosis and malaria. Early 2012, the GF had committed more than US $22 billion for over 1,000 grants in 150 countries. Public donors contributed approximately 95% of pledged funds totaling $28.3 billion. The United States was the largest contributor (over $6 billion), followed by France, the United Kingdom, Japan, Germany and the European Commission, all with contributions of over one million dollars. The Bill & Melinda Gates Foundation was the largest private sector donor with $650 millions. Other substantial contributions came from the Product(RED) campaign where partners like Starbucks coffee, Apple computers, and Bugaboo strollers earmarked part of their sales of specific products. Donations to the GF also come in kind, for example as medical supplies and pharmaceuticals, marketing campaigns, advocacy, and grant writing (Global Fund web site, 1 May 2012) (such contributions in kind by industry are not costless to taxpayers in the donor countries, however, as most are valued at market prices, not production costs, and tax deductible to the industry). GF grants supported the treatment of 3.3 million HIV/AIDS patients, 8.6 million people with tuberculosis, and the distribution of more than 230 million anti-malaria bed-nets (Global Fund web site, 1 May 2012).

In its first decade, GF faced growing pains and internal and external challenges. The growth in contribution leveled off and some major donors even failed to fulfill their financial
promises, while the costs of providing health solutions continue to grow. In 2010, under fiscal stress due to the global financial crisis, the major donors committed $11.7 billion instead of the $13 billion requested. In response to this shortfall, GF reviewed ongoing grant applications and programs, cut its grants and targeted the funding to areas in greatest need (Global Fund “Making a Difference” 2011). It also found nontraditional sources such as multinational corporations--especially those with vested interests in the recipient countries. Some donors agreed to pay ahead of schedule. New donors and partners included China (for programs in China itself), Kuwait, and the Chevron Corporation.

The first independent *Five-Year Evaluation* in 2009 compared objectives with results and concluded that generally, the GF had functioned fairly well (Macro International 2009). The evaluation also pointed to areas for improvement: prevention at the community level; investment in community systems and country health systems; novel approaches to gender inequalities; improved treatment; strengthening of disease surveillance, and surveys to measure impact and progress toward the MDGs. Clearly, those recommendations pushed the GP to reach beyond its original mandate (or “mission creep”).

Another challenge to the GF was the widespread media coverage in 2011 highlighting fraud and financial mismanagement by some of the grant recipients, initially reported by GF’s internal office of the Inspector General (High Level Panel 2011). This tainted its reputation as a fast and smoothly working grant-giving machinery. GF immediately suspended grants under suspicion, terminated some grants and tightened its control and monitoring mechanisms. The Fund installed the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms. The Panel found evidence of fraud and mismanagement amounting to $19.2 million, mostly due to “unallowable expense” (not included in the original grant application) or “incorrect categorization,” and about $17 million outright fraud (amounting to less than 0.2 percent of GF’s total program, Review Panel 2011). The Panel report recommended improved accountability, and longer-term involvement in the follow-up of programs. It also proposed a shift from emergency to sustainable response (widening GPs agenda), strengthened risk management and improved internal governance. GF’s Board adopted the Consolidated Transformation Plan in late 2011 to improve internal management, grant processing, monitoring and evaluation, and administration of the board itself.

**The Global Alliance for Vaccines and Immunization**

The Global Alliance for Vaccines and Immunization (GAVI), created by the Bill and Melinda Gates Foundation started its operations in 2002. Both GAVI and the GF, as we argued above, are examples of “partial exit” of donors from traditional channels for development aid. GAVI aims to improve access to essential vaccinations for poor populations in poor countries. It supports immunization programs, injection safety measures, strengthening health systems, the build-up of civil society organization and the development of new and underused vaccines (GAVI Evaluation 2009). By 2007, GAVI had disbursed over 1.4 billion US dollars. By 2012, donor commitments amounted over $16 billion dollars for the years 2011-2015. The major donors are
the U.S., the U.K., the Bill and Melinda Gates Foundation, Australia, Italy, France, Norway, Sweden, Canada and The Netherlands. Over 75% of GAVI’s money comes from governments, one quarter from private donors.

Like the GF, GAVI is a public-private partnership that brings together governments, civil society organizations, the private sector and international organizations. GAVI and the GF both function primarily as funding mechanism to address shortcoming in the access to health care. Both do not consider themselves as implementing entities (although over time, they both found themselves increasingly involved in implementation and administration of programs). They seek to leverage additional financial resources to support their activities; they both have more or less independent evaluation mechanisms; both seek to disburse their funds rapidly, without undue bureaucratic burden; both espouse the importance of transparency, accountability and effectiveness of their projects.

Major differences between GAVI and GF concern the eligibility as GAVI support is limited to low-income countries, GF also includes middle-income nations; focus: GF focuses mainly on three major diseases (malaria, tuberculosis and HIV/AIDS); GAVI has a wider scope of disease and activity; administration: GAVI is directly involved in implementation, GF limits its role (mostly) to finance activities of other organizations, and GAVI pays more attention to health system development than GF. Further differences regard grant application procedures, project reporting and external transparency. GF requires countries to submit proposals in a competitive application process; GAVI has an open door policy and provides technical assistance to applicant to reduce access barriers to funding. Neither organization has in-house expertise for health reforms and system strengthening, or (adequate) in-house capacity to coordinate or oversee their programs.

GAVI also drew criticism from international experts. While many poor children worldwide have benefitted from enhanced access to basic vaccines (documented by GAVI’s internal evaluations), its vaccination programs are not self-sustaining. The high costs of vaccines and costs of distribution require permanent high levels of (public) funding and infrastructure (Boseley 2011). Some critics argue that the presence of pharmaceutical companies on GAVI’s board creates a conflict of interest. Others question whether GAVI, in fact, reaches the poorest populations it claims to serve. They also point to the lack of open debate about the long-term efficacy of the vaccines that GAVI provides, and to the fact that in spite of reduced prices, the cost of many pharmaceuticals are still too high for most of the patients in need of those drugs.

4. Large International Nongovernment Organizations: MSF and the Bill and Melinda Gates Foundation

This section discusses two major health-oriented NGOs: MSF and the BMGF. NGOs are hardly a new phenomenon. European missionary societies combined export of religion with education and health support around to world since the late 16th century. The 19th century cooperative
associations in Western Europe supported by labor movements, religious and other charitable organizations, also became active across borders. Some of the large NGOs have existed for many decades, for example the (American) Rockefeller (1911) and Ford Foundations (1936). But the majority of the current health-oriented NGOs were created in the last three decades of the 20th century. NGO activities span a wide range of causes, for example arts and education (particularly important for American NGOs), environment and social concerns.

NGOs occupy the space between governments, markets and citizens: “Health NGOs exist because there are needs that are not being met by governments or international agencies” (Yanacopulos 2008). NGOs income consists mostly from voluntary contributions and (sometimes substantial) government subsidy. While there has been a very rapid growth in the number of smaller NGOs in the last three decades, this growth has leveled off, and NGOs face a decline in popularity after media coverage of incidents, fraud and abuse and lack of results (Brown et al. 2006; Blank and Hulme 2012).

**Médecins Sans Frontières (Joanne Liu)**

Doctors Without Borders (Médecins Sans Frontières, MSF) is an independent international humanitarian organization, founded in France in 1971. MSF employs over 27,000 health professionals, logistics experts, administrative support, and many others. MSF has 23 national associations, with offices around the world. MSF has 3.8 million donors worldwide who contribute over 15% of its revenues, with the remaining amounts from governments or other organizations (MSF annual report 2011).

MSF’s core goal is to provide emergency medical care to victims of man-made or natural disasters, and unstable contexts due to economical crisis and other causes. MSF also considers itself as a voice for underserved populations, influencing global and national health policies in different international platforms, and interacting with key global actors. MSF does not consider improving the health of the population in low-income countries as a core objective per se, but does contribute to it at the field level in its medical projects.

MSF assists patients suffering from neglected diseases such as sleeping sickness, Buruli ulcers, Changas disease, as well as HIV/AIDS and MDR-TBC, and provides support for marginalized populations like street children, sex workers and immigrants. MSF has an important advocacy role, too. It pushed some issues on the international health policy agenda, in particular neglected diseases and the R&D agenda for specific neglected diseases, and contributed to international attention for malaria, HIV/AIDS, tuberculosis and mental health. MSF played a major role in the Drugs Campaign in the late 1990s and early 2000s, and became active in the treatment of other chronic diseases. Through the DNDI (Drug for Neglected Diseases Initiative), MSF supports the development and distribution of vaccines, for example, for H. Influenza, pneumococcal and E. Coli. In 2010, MSF launched a campaign in support of routine polio vaccination and lower vaccine prices.
Perhaps more than any other NGO, MSF engaged in extensive and open critical debate about its own future. This critical self-assessment followed some serious incidents, including a few cases of abductions and even deaths of MSF workers. Magone et al. (2011) describe some of the dilemmas for the future directions of the organization. Some participants to the debate feel that MSF should use more of its leverage and directly influence policy-making (the more public health oriented view). Others argue that the focus should remain on answering direct field needs. In practice, those two viewpoints are already converging as MSF contributes both through its operations and lobbying efforts. Views also differ about the degree of financial and operational independence of MSF. Some argue that MSF should not accept any institutional funds to safeguard its independence. But they also recognize that it is impossible to remain 100% independent. This is largely an ideological debate. With respect to sub-contracting to local NGOs, MSF has been a loner in the field: it mostly administers its own projects, for different reasons. This independent operation has sometimes led to isolation of the organization, but some MSF leaders think it is easier to “lead from the periphery” rather than work with other agencies. Nevertheless, the organization faces criticism for creating “islands of excellency” that are costly (if of high standard) and result in collapse of the project when local organizations or governments cannot take over afterwards. In terms of accountability, MSF has sometimes paid more attention its financial stakeholders than to the patients and host countries. Brief, there has been much soul-searching and internal debate about MSF’s mission and results by MSF leaders and external critics alike (Magone et al. 2010).

The Bill and Melinda Gates Foundation

The Bill and Melinda Gates Foundation (BMGF) is the largest private foundation in the world. Its main aims are to improve health and reduce poverty worldwide, and to improve education in the United States. BMGF started in 1994 with an initial gift by Bill Gates of US$94 million, expanding exponentially by follow-up donations by Gates. Next, its assets doubled by the donation by Warren Buffet of over US$ 20 billion (to be disbursed over the next decades) in 2006. As the two main contributors had given most of their money in stocks, BMGF endowment had risen to almost US$60 billion dollars in 2012. To keep its tax-exempt charitable status, the Foundation must donate at least 5% of its assets every year, or almost US$3 billion. BMGF channeled much of its money via newly established organization like the GF and GAVI, but also via existing IOs like the WHO and the World Bank. The most striking feature of BMGF (sometimes labeled “the new 800 pound gorilla”), are its sheer size and its lofty ambitions to eradicate some of the major diseases of the world (Yamey 2002). It became a major player in health-oriented research, with large grants for disease-specific programs to fight malaria, tuberculosis, HIV/AIDS and polio, but also, substantial grants for lesser-known diseases.

BMGF has drawn much admiration, but also criticism from different quarters. The income of the foundation depends on technology that according to some commentators has
worsened the problems of poverty and pollution in the developing world (LA Times 2007). The concentration on a few specific diseases crowded out attention for others, and the focus on technological solutions led to neglect of the root causes of poverty and disease. Some programs of the Foundation require large numbers of experts to administer the funding streams and projects. This sometimes leads to “poaching” of staff from other NGOs and local health departments as projects can afford to offer higher remuneration, aggravating problems of understaffing and weak administrative capacities (Garrett 2007). The allocation of BMGF resources does not reflect the “burden of disease” of recipient countries (McCoy et al. 2009). There is very limited representation of stakeholders on the board of the BMGF (apart from Gates family members), and lack of transparency in financial reporting and evaluation mechanisms. Finally, the Foundation has not shown itself open to debate with external commentators.

5. The Role of IOs and NGOs in a Small African Country (Susan Watkins)

(THESE SECTION STILL REQUIRES MAJOR EDITING)

This section analyzes the role of smaller NGOs in health and health care in a small and low-income African country, Malawi. Those issues not unique to Malawi, but we see them as illustrative of other low-income nations. Malawi has a rapidly growing population of 14 million in 2008. It faces major health problems, but only has modest (public or private) resources for health, with a growing dependence on external funding. Despite the relative high income growth in recent years (7% between 2000 and 2008), the large majority of the population lives below the poverty line. The average income per person was $290 in 2008 (in real terms $ 830). Total external aid amounted to $53 per person in that year (World Bank 2010). The country saw some improvement in health statistics, such as a decline in child and maternal mortality and a modest increase in life expectancy at birth from 40 to 50 years between 2000-2007, but also persistently high levels of HIV/AIDS. The low level of health care resources reflected in low inputs: less than one physician (and only 6 nurses) per 10,000 habitants. The share of GDP for health care rose from 6.0 to 12.9 percent between 2000 and 2006, with a rising share of government spending, from 43.8 to 69.0 percent (the latter largely due to increase in foreign aid that went up from 26.9 to 59.6 percent in total health spending). This seems a dramatic rise in the share of external resources for health care but in absolute terms, between 2000 and 2006, total health spending rose from only 9 to 21 dollars (or from 38 to 62 PPP dollars) per person per year.

Malawi is an example of a small African country where IOs and external NGHOs play an important role in shaping of health policy and developing health care services. There are hundreds of health-oriented NGOs that commonly support local communities and some specific, narrowly focused causes (e.g. education or housing for orphans of HIV/AIDS victims). Many NGOs are Christian and Islamic religious organizations that explicitly serve both religious and social goals including health-oriented activity. Many of the larger NGOs and IOs are present in Malawi as well, including the French and Belgium MSF, the William J.Clinton Foundation, several bilateral donor agencies and the World Bank. Many of the smaller NGOs not registered, escaping scrutiny of the national Ministry of Health (Schulpen 2007)
Some of the issues: limited capacity of the national MoH, but many external organizations seeking contact (and influence on national policy-making), overburdening local administrative capacities, and sometimes draining national resources (office space, transportation, local experts, communication, expat housing). Adding to fragmentation as each IO and NGO has its own agenda (with sometimes open turf wars), policy directions and standard operational procedures, e.g. for grant applications, financial processing, auditing and accountability. Often mixed with strong religious and ideological preferences (sexual abstinence, women’s rights etc). Growing financial dependence on foreign aid, creating an expanding constituency. Lack of overall transparency; and for the smaller NGOs lack of accountability (e.g. only regular newsletters to the donors “back home”) and no clear representation of local interests and affected populations. Hard to develop coherent set of national priorities, or to strengthen national governance capacity. NGOs are often very small (almost 80% of the 100 or so Dutch NGOs active in Malawi had an annual budget of less than 200,000 dollars, see Schulpen 2007), oriented to one or a few local projects that do not necessarily fit into national or regional priorities. Run by volunteers (who do not always have the right expertise) or expats working for foreign NGOs, collaborating with small local organization or individuals, those NGOs tend to act as parallel independent organizations. Their activities are often driven by personal motivation of “doing good” (in several cases, prompted by an accidental vacation visit to the country), but without due consideration of efficacy, effectiveness or lasting impact. Those small NGOs often fill the gap left by bigger NGOs who are moving away from “bricks and mortar”, shifting towards capacity building of civic society or strengthening government administration. One major problem with such brick and mortar projects (e.g., small schools or health clinics or orphanages) is uncertainty over their longer term viability. Building a school or small clinic is one thing, but keeping it running over many years or even decades is quite another one. That requires continuous funding for maintenance, supplies and salaries for paid staff, among others.

6. Evaluating International Organizations

Health-oriented IOs, PPPs and (large) NGOs have largely similar goals: to improve the health of the world’s (poorest) populations and strengthen national health care systems. But they have very different organizational structures, models of interest representation and decision-making powers, and internal and external evaluation mechanisms to assess and report results. Moreover, as noted above, health is a complex outcome of a wider range of factors than the provision of medical care alone. For example, good health strongly correlates with higher income, thus raising family incomes generally benefits health (of course such statistical correlation is an average so it does not apply to everybody in the group). And finally, health policy goals are wider than just improving health; they include protecting family incomes, safeguarding universal access to health services and a fair distribution of the financial burden in the financing and provision of health care services. They also include the protection of patients and health professionals, and the support of medical research as part of national industry. The NGOs and
IOs discussed in this paper have a wide variety of specific policy goals, orientations and resources. Such multiple policy goals, instruments and multifactor causal relations between policy efforts and health results make it hard to realistically compare the activities and results of IOs, PPPs and NGOs.

We can, however, envision a multi-dimensional qualitative evaluation based on a systematic comparison of the stated policy goals, claims and results, governance principles and evaluation mechanisms of the IOs and NGOs, as well as summaries of external commentary about their strengths and weaknesses (see the scheme below). We drew the information for this framework from internal documents, websites, interviews and general literature review.
Table 2  Goals, means, interest representation and accountability, evaluation mechanisms, and strengths and weaknesses of selected health-oriented IOs and NGOs

<table>
<thead>
<tr>
<th>Organization</th>
<th>Goals</th>
<th>Means</th>
<th>Representation</th>
<th>Evaluation/accountability</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
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<tbody>
<tr>
<td>IOs</td>
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<tr>
<td>United Nations agencies</td>
<td>Improving health; strengthening health governance; support for national policy-making</td>
<td>Technical expertise, publications; policy advise (no money); (moral) authority on issues of public health; Health database</td>
<td>World-wide membership; one country one vote</td>
<td>Internal review and external review by independent panels of experts</td>
<td>Universal membership; long tradition as leading agency in public health</td>
<td>Large bureaucracy; weakened position in the international arena; limited financial resources; dependence of voluntary contributions;</td>
</tr>
<tr>
<td>WHO</td>
<td>Economic growth, poverty reduction, improvement of health, health care and health care systems</td>
<td>Technical assistance; policy advice; money (loans, grants, investments); consensus building among policy elites</td>
<td>World-wide membership; one country one vote</td>
<td>Extensive internal auditing and project evaluations reported externally</td>
<td>Highly qualified and experienced staff; long experience; ample financial resources</td>
<td>Large bureaucracy; neoliberal economic policy bias; collaboration with governments; sometimes neglecting affected communities, environment and other problems</td>
</tr>
<tr>
<td>World Bank</td>
<td>Economic growth, poverty reduction, improvement of health, health care and health care systems</td>
<td>Technical assistance; policy advice; money (loans, grants, investments); consensus building among policy elites</td>
<td>World-wide membership; votes according to economic importance of member states; little direct influence of affected communities</td>
<td>Extensive internal auditing and project evaluations reported externally</td>
<td>Highly qualified and experienced staff; long experience; ample financial resources</td>
<td>Large bureaucracy; neoliberal economic policy bias; collaboration with governments; sometimes neglecting affected communities, environment and other problems</td>
</tr>
<tr>
<td>OECD</td>
<td>Promote fiscal stability, economic growth and social progress in member states</td>
<td>Policy advise (but no money); country reports; expert meetings; OECD Health database</td>
<td>All members (rich industrialized countries only) represented on the board</td>
<td>Not much evaluation; most work consists of analytical studies, development of statistical databases and policy advice</td>
<td>Highly qualified staff; generally respected analytical work; consensual decision-making</td>
<td>Focused on economic policy of member states (except the Development Assistant Committee)</td>
</tr>
<tr>
<td>II PPPs</td>
<td>Improved access to affordable drugs, with</td>
<td>Grants; advocacy</td>
<td>Major donors, other NGOs and private sector on the board</td>
<td>Limited external evaluation</td>
<td>New and faster channel for disbursing</td>
<td>Focus on specific disease categories</td>
</tr>
<tr>
<td>GAVI</td>
<td>Improved access to affordable drugs, with</td>
<td>Grants; advocacy</td>
<td>Major donors, other NGOs and private sector on the board</td>
<td>Limited external evaluation</td>
<td>New and faster channel for disbursing</td>
<td>Focus on specific disease categories</td>
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<table>
<thead>
<tr>
<th></th>
<th>Focus on HIV/AIDS, malaria and tuberculosis</th>
<th>Donor aid</th>
<th>“crowds out” other causes; lack of attention to long term needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Global Fund</strong></td>
<td>Health-oriented aid to improve access to health care for poor populations</td>
<td>Executive board (20 members) includes donor and recipient nations, private sector and local NGOs</td>
<td>Reporting by recipients; evaluation by independent consultants and internal</td>
</tr>
<tr>
<td></td>
<td>Grants for “Country-led” programs; administered by local NGOs, private sector and governments</td>
<td>Faster disbursement, innovative procedures; local “ownership”; self-assessed flexibility</td>
<td>No permanent donor support (uncertain future); variety of ideas creates (too) much diversity and barriers to efficient administration</td>
</tr>
</tbody>
</table>

| **III Large NGOs**   | Rapid support for victims of manmade or natural disasters | Emergency medical care to populations in war zones; advocacy for underserved populations and neglected causes | National MSF offices represent voice of recipients; donors considered as major constituency and proxy for target populations |
|                      | Improving health, reducing poverty | National MSF offices represent voice of recipients; donors considered as major constituency and proxy for target populations | Serious and open debate and efforts to improve evaluation |
|                      | Grants to NGOs and IOs; research funding for specific diseases; focus on selected causes and diseases | Limited board membership (restricted to Gates’ family members) | Highly motivated staff worldwide; rapid response capacity; broad support in donor countries |
|                      | Advocacy, small scale project support; linkages with local populations | Limited or absent external auditing | Narrow focus; and somewhat isolated position; weak long term commitment |

| **BMGF**             | Improving health and living conditions of underserved communities | Limited board membership (restricted to Gates’ family members) | Limited or absent external auditing |
|                      | No clear external accountability (usually newsletters to constituencies “back home”) | More flexible than IOs; rapid decision-making over allocation of grants; large amounts of money for specific causes | Not much external accountability; sometimes too dominant in a particular area |

| **IV Small NGOs**    | Advocacy, small scale project support; linkages with local populations | No clear external accountability (usually newsletters to constituencies “back home”) | Growing debate about the need for independent evaluation, but not much concerted action |
|                      | Local knowledge and involvement | Local knowledge and involvement | Lacking long term commitment; working in isolation; adding to fragmentation; not always qualified staff |

Source: authors, websites IOs and NGOs
6. Conclusions and outlook for the future

In this contribution, we discussed the changing roles and activities of the major health-oriented IOs and selected NGOs, analyzing their stated goals, their means and policy instruments, form of stakeholder representation, internal and external accountability, and their strengths and weaknesses. We considered a range of organizational and public policy theories that help explain the changing landscape of international health-oriented organizations (that all pay a role, one way or another, in the international health governance).

The establishment of large IOs (and PPPs) can be explained by principle-agent theory. At the time of their creation after the Second World War, member states clearly saw the need of collective action to prevent another war and foster economic growth. They agreed on the establishment of specialized agencies for specific tasks. Over time, however, several IOs and the large NGOs widened their agenda and engaged in activities beyond their original mandates. One approach to assess such changing behavior (“mission creep”) is to view those IOs as large bureaucracies. Large bureaucracies consist of a multitude of internal divisions and departments and quasi-autonomous bodies that all have their own (sometimes competing or conflicting) agendas, goals, and operational procedures Allison (1971). Large IOs (as well as PPPs and NGOs)—similar to government agencies—face internal and external pressures of competing ideas, interests and (political) institutions (Klein and Marmor 2009). Ideas matter. For example, critics have been successful in advocating greater orientation on underserved populations and causes (e.g., women’s health, orphan drugs or environment) of the World Bank. Organized stakeholders affect policy-making, for example major member states of the World Bank actively supported neoliberal, market-oriented health policies that ultimately also prompted WHO to change direction. Politics matter, too. Formal structures of representation—and the rapid growth of new international platforms for policy debate—give more voice to some states or stakeholder groups than others.

The World Health Organization, we showed, acted as the leading force in the shaping of national health policy in low- and middle-income countries during the first three decades after the Second World War. That position increasingly came under fire since the late 1970s. The World Bank became the dominant funding source for health care, and the OECD became a major source of statistical data, policy analysis and policy advise, exercising its “soft power” to influence health policies across the world. Next, the large IOs lost terrain to the newly created PPPs and some large NGOs as major donor governments increasingly channeled their foreign aid money via those organizations (but instead of exiting the traditional organization, they showed “partial exit”). Large PPPs (e.g. GAVI and GF) and NGOs (especially the Bill and Melinda Gates Foundation) became major players in the international health arena, gaining influence (“soft power”) without explicit mandate or democratic representation.

The shifting focus and expanding ambitions of existing organizations, and the creation of a few large PPPs and NGOs, and scores of smaller NGOs in the last three decades resulted in growing overlap in activities, fragmentation in activities and blurring borderlines between public and private responsibilities. This multitude of foreign aid channels combined with shifting donor preferences over time to create an unstable landscape in the health-oriented
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development activities. The rise and expansion of new organizations and informal networks created new meeting grounds for both “old” and “new” policy elites. Despite some convergence in policy thinking, there has been common little reflection or agreement on the role of IOs, PPPs and NGOs in overall agenda-setting and directions of national health policy-making. The organizational proliferation has not been successful either in reducing the burdens of the presence of external agencies in the national policy arena.

Millions of persons in low- and middle-income countries have benefitted from improved access to drugs, malaria nets and other medical services thanks to the expanded activities of traditional IOs and new PPPs and NGOs. But there has been growing criticism of the organizations. Some are too dominant (two “800 pound gorillas” in the room take up a lot of space, crowding out other causes and dissenting views). Other organizations are too narrowly focused on specific disease categories, neglecting or other causes. Each organization has its own ideological preferences, policy direction and policy agenda, rules for grant applications, financial reporting, monitoring and auditing and other procedures that create (sometimes enormous) administrative burdens for recipient countries. The very presence of large numbers of IOs and NGOs commonly overburdens local bureaucracies (many of them want regular contact with the Health Ministry) and undermines local capacities by “poaching” qualified staff” and creating heavy demands for expat housing, office space and transportation. Affected communities are not well represented in the governance of IOs, PPPs and NGOs, and several organizations have weak accountability or evaluation mechanisms (Witz, undated).

Internationally, there is growing awareness of need for better governance, transparency and accountability of the foreign health-oriented activities, but no agreement on how to do that. The large IOs and NGOs often give (and receive) contradictory advice on issues of health administration, but they do not seem to engage in much coordination between themselves. The dramatic growth and widening agenda of NGOs and PPPs in the last three decades added to fragmentation and overlap in the field of health care and health policy. Finally, whatever the (potential) importance of the IOs (and NGOs) in agenda setting and shaping policy directions, their role in domestic financing of social policies and health services is at the margin. Only in a few cases the external development aid plays a major role in health care funding.

So what can we expect for the future? Once in place, as Pierson (1995) argued, large organizations create constituencies that will support their long-term survival. The large PPs and NGOs discussed in this paper will not likely disappear soon. But as their funding largely depends on governments and a few large donors, they will have to deal with changing demands and fashionable policy ideas.

One trend that is already visible is the increasing emphasis on “good governance” of IOs, PPPs and NGOs (in particular in regard to their transparency and accountability). This will make them look more like (local) government agencies. That shift in emphasis has consequences for the theoretical approaches to study IOs and NGOs, as general models of (public) decision-making and public policy increasingly apply to those organizations.

Another trend is the increased focus of international health-oriented organizations on fewer and fewer countries as many middle-income nations (especially some of the rapidly
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growing countries in Asia and Latin America) have taken over basic responsibility for their health care systems and no longer need external support.

Third, there will be further changes in the distribution of decision-making power and representation of national states in the large IOs. With the growing importance of emerging economies in Asia and Latin America, the large shareholders of North America and Western Europe will lose (relative) voting powers (and in reaction, may engage in further partial exit).

Finally, we argue that there is need for a critical assessment of the goals, actual activities and results of the IOs and NGOs, based on systematic evaluation of their activities, shifting agendas and changing positions as major players in the (national and international) health arena.
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Fisher


Fowler


Godlee series BMJ 1999


IHMI 2013


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Verkaueren et al. 


WHO Working Group 2013


Websites:

www.BMGF.org
www.GAVI.org
www.GF.org
www.IBRD.org
www.IHMI.org
www.MSF.org
www.OECD.org
www.UN.org
Some authors differentiate between “national” non-governmental organizations (NGOs) and international ones (INGOs). In this paper, we mostly focus on the latter, but label both categories as NGOs.