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## The Global Role of the World Health Organization

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### Abstract

The 21<sup>st</sup> century global health landscape requires effective global action in the face of globalization of trade, travel, information, human rights, ideas, and disease. The new global health era is more plural, comprising a number of key actors, and requiring more coordination of effort, priorities and investments. The World Health Organization (WHO) plays an essential role in the global governance of health and disease; due to its core global functions of establishing, monitoring and enforcing international norms and standards, and coordinating multiple actors toward common goals. Global health governance requires WHO leadership and effective implementation of WHO's core global functions to ensure better effectiveness of all health actors, but achieving this global mission could be hampered by narrowing activities and budget reallocations from core global functions.

### Globalization and health

Globalization offers opportunities and challenges for global health and its distribution.<sup>1</sup> Prospects for health improvement are enhanced by the transfer of medical and public health knowledge and technology from one part of the globe to another, through, for example, sharing of best practices, health promotion and prevention strategies and, of course, medical treatments. Further, all countries benefit from international norms and standards and sustained global advocacy for health. Outside the health sector the benefits of globalization range from progress on gender empowerment and human rights to better prospects for trade, information technology,<sup>2</sup> and economic growth.<sup>3</sup>

Globalization has also accelerated the spread of infectious diseases, as evidenced by the rapid outbreak of Severe Acute Respiratory Syndrome (SARS), exacerbated existing health inequalities between and within countries, and been associated with global marketing of unhealthy consumption patterns. Thus, the primary challenge with twentieth century globalization relates to global inequalities and externalities, in terms of not just health<sup>4</sup>, but other economic and social indicators as well.<sup>5</sup>

The distribution of health benefits that result from the globalization process depends on preexisting economic, social and political conditions within countries, the fairness of trade and investment agreements, existing political economy and the strength of the multilateral global health system. Globalization presents certain problems that are substantial and beyond the capacity of individual states to manage. Avoiding the perpetuation of an international class of very poor countries excluded from most of the benefits of the global economy, requires multifaceted and sustained support and cooperation by the international health community at large.<sup>6</sup>

## The *global* in global health governance

Improving health and addressing health inequalities and externalities requires effective international action on health that entails essential *global* health functions beyond what individual nation-states can accomplish, even with external assistance. Global functions can be distinguished from national or sub-national functions in that they are beyond individual states' capacity and entail such categories as; norms and standards, global action, professional management, financial resource transfer, scientific research capacity, and leadership.<sup>7</sup> International health actors have different roles in relation to these global functions.

Global health functions can also be distinguished as actions taken to promote global public health goods; measures that are also beyond the reach of individual governments and independent groups, but that benefit all countries, even at the country level.<sup>8</sup> Global health goods include: global advocacy for health; the use of bio-ethical and human rights instruments; surveillance for diseases and risk; direct global action; investment in essential health problems; and the use of norms and standards.<sup>9</sup> Examples of such functions range from a World Health Organization (WHO) 2001 World Health Day focus on mental health as a global health priority, to WHO's promotion of international ethics and human rights through international legal instruments, and to WHO leadership in developing global norms and standards such as the International Code of Marketing of Breast-milk Substitutes, the Framework Convention on Tobacco Control and the WHO International Sanitary Regulations.

## Pluralism in global health

In the first few decades following the creation of the United Nations (UN) and WHO, there were few major international players with the political and/or financial clout to influence global agendas. WHO, the Rockefeller Foundation, United Nations Children's Fund (UNICEF) and only in the last two decades, the World Bank<sup>10</sup> have in the past heavily influenced global health priorities for research, policy and investment.

In the midst of an increasingly globalizing world, however, a new international health framework is emerging; one that is no longer dominated by a few organizations, but that consists of numerous global health actors. WHO is now joined by many other players - some with a primarily financial investment function and others with mixed finance-policy-operational functions.

Health debates have moved out of cloistered health departments and the WHO, and are now regularly a part of G8 and other multilateral meetings. The World Economic Forum has sponsored deliberations about health issues ranging from HIV/AIDS and vaccines to obesity and tobacco control. The UN Security Council has addressed HIV/AIDS and the private and non-profit sector has developed as a force in international health as relatively new players like the Global Fund for AIDS, Malaria and Tuberculosis (TB), the Bill and Melinda Gates Foundation,<sup>11</sup> and pharmaceutical companies such as Merck, Pfizer, Novartis and GlaxoSmithKline play more important roles. Over 50 private-public partnerships have been established to address infectious diseases or micronutrient deficiencies. Some like the Global Alliance for Vaccines and Immunization (GAVI) have multi-billion dollar budgets. International Nongovernmental Organizations (NGOs) including Médecins Sans Frontières (MSF), Oxfam and CARE now work in disaster relief and health emergencies and contribute to policy development on issues like access to essential medicines.

Global health has benefited greatly from these new funds, initiatives and actors. This pluralism, however, has resulted in a splintering of international health agencies and an

increasingly fragmented, uncoordinated, *ad hoc* and incongruent global health agenda, creating a leadership gap for an overarching convening and coordinating role. Within this multi-lateral environment, WHO maintains its unique coordinating function as derived from its Constitution. It is the only agency with the authority to develop and implement international health norms and standards and facilitate ongoing dialogue among member states on priorities. The benefits of cooperative supra-national action on global health issues, while numerous, could, however, be hampered by a shift in WHO's budgetary allocations and policy priorities away from global normative development toward operational work at the country level.

We consider the implications of these changes for the future of global health governance and in particular, the future of WHO.

## WHO constitution, core functions, and proposed reforms

The work of the WHO is defined by its Constitution, which divides WHO's core functions into three categories: (1) normative functions, including international conventions and agreements, regulations and non-binding standards and recommendations; (2) directing and coordinating functions, including its health for all, poverty and health, and essential medicine activities and its specific disease programs; (3) research and technical cooperation functions,<sup>12</sup> including disease eradication and emergencies.

Over the past fifty years or so, the WHO has gone through various permutations in prioritizing different aspects of these categories over others, and its effectiveness in doing so has been the subject of analysis and criticism.<sup>13</sup> For example, in one of the most comprehensive analyses of the WHO, Fiona Godlee critiqued WHO's management, effectiveness, policy choices, headquarter-regional negotiations and power struggle, and its weak operational capacity in a series of articles in the *British Medical Journal* in the mid-1990s.<sup>14</sup> At about the same time, a self-study commissioned by the WHO analyzed the institutions effectiveness in implementing its core functions and recommended reforms focused especially on strengthening its technical capacity and its global health and coordinating functions.<sup>15</sup> And in 1996–1997, the WHO Executive Board held 6 special meetings to review the Constitution, recommending rewriting WHO's core functions to emphasize coordination, health policy development, norms and standards, advocating health for all, and advice and technical cooperation.<sup>16</sup>

In the late 1990s, a group of international health scholars and practitioners gathered in Pocantico, New York for a retreat on “Enhancing the Performance of International Health Institutions” to examine whether the institutional structure in international health was sufficient for a 21<sup>st</sup> century of global health interdependence. The Pocantico report concluded, “the importance of WHO was seen primarily for its global normative functions which need to be strengthened and updated,”<sup>17</sup> that “the emphasis on technical assistance has often come at the expense of the normative role”, that “WHO should be the ‘normative conscience’ for world health” and that “WHO should assume leadership in achieving more coherence and equity in the system.”<sup>18</sup> A clear emphasis was placed on WHO's global, especially normative, functions. This perspective was reiterated in an article by Jamison, Frenk and Knaul,<sup>19</sup> who argued that WHO had two separate types of functions: core (including global normative work) and supplementary (including technical cooperation). While the demand for both types has increased, the majority of new global health actors address primarily operational functions, creating an even greater need for WHO's core *global* functions.

## Decisions about the future of WHO's work

Governments convened in Geneva in May 2009 to decide on the future budget for WHO, in what was Director-General, Margaret Chan's third World Health Assembly. Their decisions will have a significant impact on the future of the organization. It was an opportunity to prioritize core functions: to decide whether WHO should reduce its global normative work in favor of becoming more operational in-country or not. In coming years, tensions will arise within WHO about budget shifts. Concerns about the future budgetary impact on many global activities in advocacy, surveillance, norms, disease classification and enumeration and research by senior staff will loom large. In 2007, Margaret Chan delineated the core functions of WHO as providing leadership on critical health matters; shaping research agenda; setting norms and standards and monitoring their implementation; presenting ethical and evidence based policy options; providing technical support and creating institutional capacity, and monitoring and assessing health trends. She advocated a focus on these core areas as the best way to co-ordinate with key players in global health, with the Medium Term Strategic Plan (2008–2013) providing a rubric for these goals and their funding. The most recent biennium reports have seen a shift in expenditure patterns across WHO's three core functions, with more resources being earmarked for work in countries and regions.<sup>20</sup> Greater emphasis on increasing capacity and managerial skills at both the country and regional levels is required to ensure greater transparency, accountability, and more efficient use of resources.

## Trends in WHO leadership

Despite the emerging consensus that a number of global health issues require distinctly global health solutions, especially in the areas of global surveillance,<sup>21</sup> norms and advocacy, coordination of new global players, and international health law,<sup>22</sup> thinking at WHO under the previous Lee administration reflected a move in the opposite direction. The WHO Commission on Social Determinants of Health (CSDH) may be a noteworthy exception to this trend. In what follows, we highlight several key policy changes at WHO in the past decade, which reflect this shift in prioritization of WHO's core functions and a narrowing of WHO's health agenda.

## Change in Director-General Emphasis

Gro Harlem Brundtland left the WHO with a legacy of having put health centrally on the development agenda, focusing on global governance in the form of international treaties and norms, and emphasizing global surveillance and systems of epidemic alert and response to translational health threats, like SARS, by building and maintaining a strong base of technical expertise. Brundtland's route to Director-General reflected this emphasis.

Brundtland was elected as WHO Director-General on her credentials and background in state politics as Norway's Finance Minister and later Prime Minister. As a result, her leadership was associated with greater independence from the regions and health ministries and an emphasis on WHO's core global functions. For example, she used WHO's convening function to spearhead the Commission on Macroeconomics and Health, the Framework Convention on Tobacco Control (with Food and Agriculture Organization (FAO) review), and health systems assessment, to enhance the Codex Alimentarius Commission and WHO-World Bank collaboration, to initiate a revision of the International Health Regulations, and to support creation of GAVI, the Global Fund and more coordination by the G-8 on international health.

Jong-Wook Lee's inspiration came from his work on TB and vaccines at WHO over two decades. His approach reflected his close advisors' laudable frustrations about the slow

progress in getting effective AIDS and TB drugs to patients. His solutions focused on shifting staff to countries, becoming more operational on drug distribution and building up country offices. This is best exemplified by WHO's 3 by 5 initiative: a commendable effort to boost access for 3 million individuals to antiretroviral medicines in developing countries by 2005.

Margaret Chan has brought a different focus. She has built on her past experience in communicable disease surveillance and response, enhanced training for public health professionals, and collaborated at the local and international level. She has focused WHO's efforts in these areas, with an emphasis on its strength in managing global outbreaks such as Avian Flu and SARS. She has also focused on the ethical principle of equity, with specific emphasis on the people of Africa and women.

### **WHO as an operational manager: The 3 by 5 Initiative**

It is hard to critique the purpose of 3 by 5, as it is well-known that antiretroviral medicines extend and improve the prospects for longevity and quality of life among AIDS patients world-wide. However, the initiative represented a significant shift away from WHO's broad-based directive. The Constitution authorizes WHO to act in the field to address urgent epidemics like SARS and Ebola and includes support for eradication programs. Lee invoked the "emergency" clause under the Constitution to justify shifts in staff and funds in developing 3 by 5, although it is unclear whether these efforts were consistent with the Constitution's original intent. This evolving interpretation of WHO's powers, moreover, predicts future WHO responses to numerous other health threats such as diarrhea and pneumonia in children.

Furthermore, 3 by 5 represents a narrowing towards specific diseases and a focus on treatment over broader health determinants and health promotion strategies. It reflects an emphasis on operational work at the country level. Given the numerous actors and financial commitment already focused on HIV/AIDS; a future WHO role could involve coordinating and convening participants to ensure institutions work more closely within agreed norms and standards.

### **Surveillance**

The WHO Constitution identifies core functions such as epidemiological and statistical services, control and eradication of communicable disease and establishing international nomenclatures and classifications of diseases and causes of death as essential to a world health information system. As a result, the WHO has assumed a vital role in this area and been involved in technical assistance to countries in developing their own health information systems. Trends at WHO in the last several years, however, suggest a shift in priorities, evidenced also by the emergence of other entities in academia<sup>23</sup> and the US government looking to fill a void left by WHO. The United States (US) Centers for Disease Control and Prevention (CDC), for example, has moved into global health surveillance by strengthening national public health and information systems; developing an integrated global disease detection strategy; and establishing a "code of conduct" for CDC and others on reciprocal information sharing.<sup>24</sup>

While these entities hold promise for more resources and expertise for global information systems, a strong WHO is still necessary, as many governments look to WHO to standardize methods, integrate information systems and ensure the reliability and validity of health statistics.

## The WHO 2009/10 budget: What set of priorities?

The WHO budgetary process initiated by WHO administration and approved annually by members of the World Health Assembly, delineates WHO priority areas each year. Budgetary analysis over the last several years highlights a few key trends in light of WHO's global functions. First, the 2006–2007 programme budget<sup>25</sup> reflected an emphasis on essential health interventions and specific diseases. Fifty-one percent of the budget, for instance, was allocated to health interventions for areas ranging from HIV/AIDS to mental health and substance abuse, including epidemic alert and response measures. Second, budgetary changes reflected a shift in resources from headquarters to the regions. The second largest budgetary allocation -- twenty-two percent of the budget, for example -- was for effective support for member states, including WHO's core presence in countries. Because WHO's regional directors have primary allegiance to Ministries of Health from the countries they serve (as compared to allegiance to WHO headquarters), efforts to strengthen WHO's country offices reflect a WHO that is more operational and less global. These signs point to more autonomy, more funding and more power to WHO regional offices, likely at the expense of such support for WHO headquarter staff and functions.

Another priority area in the 2006–2007 programme budget included thirteen percent allocated for health policies, systems and products, which includes areas of work ranging from health financing and social protection, health information, evidence and research policy to policy-making for health in development. In the previous WHO administration, by comparison, "evidence for health policy" as a work area increased thirty-three percent and "organization of health services" increased by thirteen percent from 2000–2001 to 2002–2003.<sup>26</sup>

A final priority area in the 2006–2007 budget<sup>27</sup> was eleven percent allocated to the determinants of health, which included related areas of work ranging from gender, women and health to health promotion, tobacco, nutrition and communicable disease research. By contrast, the previous WHO administration increased spending on tobacco by fifty-seven percent and safe motherhood programs by 237 percent between 2000–2001 and 2002–2003.<sup>28</sup> We are yet to see the results of this recently promulgated budget, and it is unclear whether Dr. Chan will stay on this course or change directions.

The 2008–2009 budget was the first in a set of three budgets that will make the Medium Term Strategic Plan (2008–2013) operational. The Medium Term Plan will inform the WHO's results-based framework by ensuring continuity in objectives and a structure that better reflects the country and regional needs. The WHO budgetary process for 2009–2010 approved in May by members of the World Health Assembly, will illuminate WHO priority areas for the coming two-year period, and will comprise the next stage in the Strategic Plan.

## WHO Commission on social determinants of health

The WHO Commission on Social Determinants of Health (CSDH)<sup>29</sup> provides a noteworthy exception to the general movement described above. The CSDH convened practitioners and academics to discuss existing knowledge on the social determinants of health and to raise societal debate and advance policies to reduce health inequalities between and within countries.<sup>30</sup> In this way, the CSDH is satisfying WHO's agenda-setting role, by recognizing the social determinants of health as a priority issue for international collaboration and state action, and WHO's role as reviewing, synthesizing and disseminating public health and social scientific information on this priority issue. The CSDH recently issued its final report and is currently in the process of disseminating its results to reduce global health inequalities. Only time will tell whether its recommendations are effective, but there is no doubting the global role of WHO in convening and focusing on this topic in the production

of global public goods for global health improvement. The emphasis on the social determinants of health has informed the Medium Term Strategic Plan. Of the thirteen strategic goals, the seventh goal is “To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.”<sup>28</sup>

## Responding to globalization and pluralism

Under Margaret Chan’s leadership, WHO must engage in the global health arena with a stronger hold on its role in integrating, coordinating and convening the global health agenda. In the past, strong WHO leadership has helped shape a number of critical global health pathways including advocating the importance of health in trade debates, human rights contexts, public-private partnerships, treaty revisions and reinterpretations (e.g., in Trade-Related Aspects of Intellectual Property Rights (TRIPS)), and in convening UN partners under the umbrella of the UN Economic and Social Council (ECOSOC) to develop a UN-wide policy on tobacco. Such leadership entails bringing together technical experts in relevant areas such as law, economics and trade, as evidenced, for instance, by the FCTC negotiations. Future WHO success on its key global functions will require significant investments in in-house expertise in a number of technical areas related to, for example, WHO’s work on FCTC implementation and protocol development;<sup>31</sup> the Codex Alimentarius Commission; revision and implementation of International Health Regulations; analysis of the impact of trade settlements on health; and efforts to move the Global Strategy on Diet and Physical Activity into an implementation phase.

For WHO to execute its mandate and serve all countries, these areas of work require support. In conclusion, three further examples of the need for strong WHO involvement in governance are identified.

One future area of global governance for WHO centers on efforts to converge on major trade issues concerning medicine. One example of such efforts is the Kyoto-style medical treaty,<sup>32</sup> which encourages countries who sign on to invest a percentage of their gross domestic product in medical innovation and enables countries to trade credits with other countries for investments in a manner similar to that designated in the Kyoto protocol to control environmental emissions.<sup>33</sup> WHO is to play a critical role in agenda setting, treaty content, consensus building and ultimately member state ratification and implementation related to this treaty. No other international organization has the normative or technical capacity or legitimacy to steward the success of efforts to address distinctly global health issues such as finding treatments for neglected diseases and orphan drugs in developing countries while at the same time addressing concerns over intellectual property protection as a means to incentivize innovative research and development.

A second major area of global governance for WHO involves WHO’s role as an umbrella health agency coordinating international legal and non-legal activities of different organizations. In this case the international health field can learn from international experience in lawmaking in biotechnology (e.g., adoption of conflicting legal standards on intellectual property by organizations with overlapping legal jurisdictions) and the international environmental arena in which the absence of an overarching agency has led to “counterproductive and inconsistent results.”<sup>34</sup> In this capacity, WHO could fill a void in global health leadership in efforts to promote more integrated and effective collective decision making in global health.<sup>35</sup>

A third major area of global governance for WHO involves continuing to reform and update existing global regulations for infectious disease control, such as the International Health Regulations (IHR).<sup>36</sup> Such work is consistent with a general consensus that improving

global health in the 21st century will require multilateral coordination and cooperation among states through both international legal and non-legal instruments and with a major role for WHO as convener, coordinator and channel for codifying future health laws.<sup>37</sup>

In conclusion, progress on WHO's unfinished global health agenda requires emphasizing its uniquely *global* health functions. In May 2009 the Executive Board and Director-General, Margaret Chan, had the task to debate and decide what priority to place on WHO's core functions and mandate; the effectiveness of the global health community in achieving global health gains will depend upon it.

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