Published in final edited form as:
Public Health. 2014 February ; 128(2): 119–123. doi:10.1016/j.puhe.2013.08.002.

WHO: Retirement or Reinvention?

Kelley Lee* **[Associate Dean, Research and Professor, Faculty of Health Sciences]**
Simon Fraser University, Blusson Hall, 8888 University Drive, Burnaby, BC V5A 1S6 CANADA, Tel: +1 778 782 9039, Fax: +1 778 782 5927

Department of Global Health and Development, London School of Hygiene & Tropical Medicine, 15-17 Tavistock Place, London WC1H 9SH UK

Tikki Pang (Pangestu) [Visiting Professor]
Lee Kuan Yew School of Public Policy, National University of Singapore, 469C Bukit Timah Road, Singapore 259772, Tel: 65 6516 5830

Abstract

WHO reform has become a perennial subject of debate that has seen familiar issues raised time and again by incumbent director-generals and member states. This paper begins by reflecting on the distinct nature of WHO reform debates since the 1990s and the global factors behind the pressures to change. It then argues for a shift in focus, from fixing a single UN organization, to the collective health needs of a rapidly globalizing world. The achievement of effective global health governance will require more fundamental changes, beginning with recognition of the shared responsibility for reform. The challenge in the twenty first century will require an even greater willingness to delegate authority and resources to a supranational entity. The compromise may be that the mandate and powers of a global health organization may need to be more carefully circumscribed, but more meaningful in terms of effectively delivering the essential functions needed to protect and promote health in a globalized world.

Introduction

The perennial wringing of hands about the World Health Organization (WHO) continues apace. We are now firmly into Director-General Margaret Chan's second term at WHO's helm, and member states and the Secretariat are once again engaged in another round of reforms that seek to address the organization's perceived faults. Reform has been a familiar subject since the organization's creation in 1948, comprised of ongoing efforts to ensure activities are relevant to the world's health needs. The results have included adjustments to the size and composition of governing bodies, tightening of financial management systems, restructuring of the Secretariat, and reorganizing of the biennial programme of work.[1,2] Such is the nature of large international organizations over time that serve a multitude of masters, and WHO has been no different from other UN bodies in this respect.[3,4]

* Corresponding author kelley_lee@sfu.ca. spptep@nus.edu.sg.

Since the 1990s, however, the quality of reform debates has been markedly different. While fixing administrative and technical shortcomings has remained a staple of reform discussions, deeper questions about the *raison d'etre* of WHO within a rapidly changing environment have been increasingly vocalized. Most recently, the continued existence of the organization has even been questioned. The reform stakes, in this sense, have become much higher, not only for the organization, but for international health cooperation as a whole.

This paper begins by reflecting on the distinct nature of WHO reform debates since the 1990s and the global factors behind the pressures to change. It is argued that there has been a disconnection, between the internal agenda for reform and such external pressures, resulting in perceptions that limited progress has been achieved. To move the reform agenda forward, it is argued that a different starting point beyond the performance of a single international organization is urgently needed, beginning with a candid look at the collective action needs of a rapidly globalizing world. Recognizing that protecting and promoting population health is one of the core aims of any effective and sustainable system of global governance, how might this be achieved through shared rights and responsibilities expressed through agreed institutions, appropriate and effective distribution of authority and resources, and agreed rules and procedures? Given the heightened need for collective health action, we conclude that the creation of a truly global health community faces a watershed moment.

Changing the record: Reform again?

WHO's perceived problems have been well-documented over the past two decades, perhaps most pointedly captured in a critical series by Fiona Godlee published in the *BMJ,*[5] but also detailed in assessments of selected WHO activities and programmes.[6-10] These varied analyses point to many commonly raised concerns: a surfeit of political appointees; fragmentation among headquarters, regional and country offices; a lack of coordination, and indeed competition for priority attention and resources, across different programme areas; an inappropriate balance between what are considered normative (knowledge generation) and technical (knowledge translation) functions; a slow and ponderous bureaucracy; a failure to make a difference at the country level; opacity and lack of transparency in the process of election of the Director-General; and an overall weakness in leadership and strategic vision.

While each Director-General since the mid 1990s has responded with a programme of internal reforms, each have been highly cognizant of a changing external environment. Hiroshi Nakajima's reform agenda focused on WHO's response to global change,[11] while Gro Harlem Brundtland's "100 days of change" was intended to make WHO "more responsive, more focused and more visible", and to put health on the global agenda, by running the organization in a more corporate style.[12] The foremost contextual change has been a shift, from *international* to *global* health, characterised by the increased importance of transboundary health determinants and outcomes. The acceleration of globalization - punctuated by the end of the Cold War, expansion of international trade and finance systems, rapid technological advances, increased population mobility, and the rise and fall of major economic powers - has transformed the world in a remarkably short time. For WHO, a response to global change was recognized as essential yet, as reforms have been adopted[11] and implemented,[13] deeper concerns have persisted about the capacity of WHO, as one

intergovernmental organization focused on ministries of health, to protect and promote population health amid fundamental changes to world order.[14]

Two key means by which major donors have expressed these concerns have been by earmarking extrabudgetary (voluntary) contributions for specific purposes,[6] and by funding alternative institutional arrangements to circumvent WHO's shortcomings. On the latter, donors initially channeled a growing part of their financial and political support to other health-related UN organizations, such as the UN Children's Fund (UNICEF), UN Population Fund (UNFPA) and UN Development Programme (UNDP). By the 1990s, the World Bank had also become a prominent source of health development funding and policy.[15] This elicited a debate about what comparative advantage might WHO offer. Did WHO represent "value for money"?[16] Then, in part to spur further and deeper reform, new initiatives such as the UN Joint Programme on HIV/AIDS (UNAIDS), Global Alliance on Vaccines and Immunization (GAVI) and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) were created. These were joined by existing and new bilateral arrangements, notably the US President's Emergency Plan for AIDS Relief (PEPFAR), the UK Department for International Development, and the emergence of major philanthropies led by the Bill and Melinda Gates Foundation. By the early 2000s, WHO was operating within an increasingly competitive market for funding, and the balance of reform questions had shifted from internal preoccupations to questions about WHO's place within this increasingly crowded institutional environment.

While increased earmarking of funds and competition for resources have been intended to motivate WHO reform, in effect, it appears that the organization's capacity to rise to the challenge has actually been diminished by donor actions over the past twenty years. With EBFs comprising around 80% of WHO's total budget by 2012,[2] making the vast majority of WHO's budget earmarked for specific purposes, WHO has by definition become a reflection of the specific and varied funding priorities of donors. In the process, however, its work has become more, not less, fragmented. In competing for resources, donor-friendly activities, such as providing emergency relief, distributing medicines, immunizing children and fighting outbreaks have been featured more prominently in an effort to generate public approval and donor support. As a result, funding of WHO's unique, yet relatively pedestrian, roles of collecting and disseminating international health data, agreeing nomenclature, producing guidelines and protocols, promoting research, hosting technical meetings of experts have been left to assessed contributions from member states, a core budget frozen since the 1980s. Reduced to one of many institutions concerned with global health, in short, WHO has been forced to chose between pursuing high-profile campaigns to attract continued donor funding, and fulfilling its unique mandate of carrying out the day-to-day tasks that form the building blocks of global health cooperation.

As the present Director-General Margaret Chan tabled her reform agenda in 2012 to the 130th Executive Board, one might be forgiven for seeing WHO as a repeat offender. A familiar menu of issues is on offer - measures to improve organizational effectiveness, a new evaluation policy, improved processes to carry out decision-making in governing bodies, a better staffing policy, renewed regional activities, and strengthened technical support to member states. Critics argue that the organization continues to rearrange the deck chairs on a

slowly sinking ship. It is clear, however, that internal shortcomings are again closely tied to external pressures. The clear message from the top is that WHO cannot change, above all, without appropriate and predictable financing.[17] In this respect, the dance between donors and WHO remains out of step. Because WHO has not changed fast enough for donors, they continue to take their business elsewhere. In doing so, the organization's financial problems have been worsened over time and disappointments about WHO's performance become self-fulfilling.[18] How can WHO and donors, and indeed the entire global health community, break out of this vicious cycle? How can trust be restored so that funding creates a strong and effective organization that is capable of addressing collective health needs?

Beyond navel gazing: From WHO to global health governance

The current practice of drip feeding WHO and, by doing so, keeping it alive but weak and ineffective, allows donors to justify funding other global health initiatives of their choice. Conversely, a lack of adequate and sustained resources is blamed by WHO for its failure to go beyond internal tinkering. All the while, there are interests circling above who would welcome the organization's demise - rival initiatives, disgruntled stakeholders and, not least, powerful corporations that benefit from weak regulatory frameworks at the global level.

Setting aside the fate of WHO, a different approach to reform is needed that begins with an understanding of humanity's collective health needs in a rapidly globalising world of the twenty first century. In 1648, the Peace of Westphalia divided central Europe into discrete and recognised territorial domains, each governed by a distinct authority, holding exclusive powers under the legal principle of state sovereignty. From these beginnings, the international states system emerged to eventually extend to the entire world, thus dividing Earth into 196 countries (including disputed entities such as Taiwan). From the late twentieth century, and driven by globalization, there is now substantial evidence that the territorially-based boundaries of sovereign states have become increasingly porous, as people, capital and information, for example, have flowed across borders to an unprecedented degree.[19,20] These flows, in turn, have created externalities such as environmental destruction, climate change, financial volatility, illicit activities and health risks that individual governments, perched upon pieces of territorial space, are unable to effectively address alone. Can humanity transition, from a world parceled into 196 territorial pieces, each governed as self-interested sovereign states, to a "deterritorialised" world of global citizens backed by institutions that tackle shared problems?

It is in relation to this higher order question that the challenge of WHO reform could be more productively located. What is at stake, therefore, is not merely the survival of one UN organization, but institutional arrangements that address the shared basic needs of globally integrated human societies. How do we evolve politically in ways that allow us, the human species, to govern ourselves so that we can best meet our collective health needs in a fair, representative, affordable and sustainable way? In short, how to we achieve effective global health governance, a term that remains contested, but in this context defined as agreed rules, processes and institutional arrangements for achieving collective health needs across populations and geographies?

With this higher aim as a starting point, how can we redirect WHO reform from navel gazing to "game changing" steps that support global health governance? To achieve this, there are shared responsibilities for the entire global health community. For WHO, rather than clinging to an historical claim to be "the directing and coordinating authority on international health work", the organization must now operate in ways that acknowledge that it is no longer the only game in town. There was a time when WHO's technical expertise was unrivaled. This is no longer the case. There was a time when ministries of health were deemed as sufficient partners. This is also no longer the case. There have been half-hearted efforts to meaningfully engage non-state actors but this remains a struggle because of the lack of clear mechanisms to do so and the diversity of non-state actors.[21,22] Instead, WHO supporters have clung to its 194-strong state-based membership as a life raft of moral authority, claiming this makes the organization the most democratic of current institutional arrangements for global health. This may be true, compared to other global health institutions, but it says more about the poor state of global health governance than about WHO's democratic credentials. The decline in the proportion of citizens voting in elections, the distrust of politicians, the lack of engagement with political institutions all reflect a period of transition by humanity towards a new "polity". How should political interests now be defined? Can one measure political identity solely according to which piece of territory (state) one happens to have membership (citizenship)? In a deterritorialised world, complex identities beyond sovereign states are emerging. This is the source of dissatisfaction by non-state actors who have railed for decades that WHO is unrepresentative of voices beyond government. In principle, the WHA is a relatively democratic body, with all member states invited to feed into WHO's programme of work, and officially recognized non-state actors as observers. In practice, questions remain about the quality of debate in the WHA, the capacity of all states to participate meaningfully, and whether current arrangements focused on government representatives adequately represent the full range of voices. Importantly, to what extent does the WHA have real power to set WHO's priorities when 80% of the organization's budget is controlled by donors, with almost all earmarked for favoured causes. Finally, there was a time when WHO's mandate, to take all necessary action for "the attainment by all peoples of the highest possible level of health",[23] meant maintaining the most comprehensive programme of activities possible. Yet like national debates about rationing health care, limited resources and unlimited demands must be unavoidably reconciled through difficult choices about priorities.

For donors, both state and non-state, financial clout should not be confused with understanding the collective needs of a global health community. A genuine commitment to a new process is needed, one akin to the International Health Conference held in 1946, where high-level political and financial support led to the creation of WHO. While the birthing of WHO was hardly an easy achievement, the challenge in the twenty first century will require an even greater willingness to delegate authority and resources to a supranational entity. The time might be ripe for such a bold move. Health issues remain relatively visible at the level of the UN General Assembly with non-communicable diseases addressed in 2010 and universal health coverage in 2013. There is also much talk of the post-Millennium Development Goals strategy after 2015, and there are concerns that health

goals will be downgraded as priorities. To ensure that this does not happen unduly, a demonstration of more effective global health governance might be needed.

Importantly, the compromise may be that the mandate and powers of a *global* health organization would need to be more carefully circumscribed, yet have more binding authority, to make its role more meaningful in terms of effectively delivering the essential functions needed to protect and promote health in a globalized world. A more streamlined programme of work, that authoritatively underpins an effective system of global health governance, might be centred around intellectual and normative leadership through standards setting, technical guidelines, codes of conduct, knowledge brokering and international legal instruments. This is supported by WHO's history, status and expert networks, as well as the absence of any alternative body that could fulfil this function. A leaner, meaner *global* health organization would need sustained and unrestricted funding, most effectively, through levies on global transactions that create health externalities (such as certain types of trade or travel). In a world of what Archibugi and Held call "overlapping communities of fate", where the interconnected lives of individuals and societies are shaped by powerful interests and/or processes which are global in scope and ramifications, there is need for a "reconfiguration of political power."[24] Left to states and markets to resolve, global health governance becomes the priorities of powerful states, corporations or bureaucratic interests. A more collective approach might be achieved, for example, through the ideas of "cosmopolitan democracy" which advocates for giving voice to new global players such as social movements, cultural communities, and minorities. Archibugi proposes building institutional channels across borders to address common problems, and encourages democratic governance at the local, national, regional, and global levels.[25]

Conclusion: WHO reform as a political challenge

There are no illusions that the building of any agreed system of global health governance will be a formidable task. The painful lack of success by states to agree binding limits on greenhouse gas emissions for individual countries, despite accumulating scientific evidence of the planetary peril faced by all, does not bode well for an intergovernmental solution to global health needs. Like climate change, however, the clock is ticking for an ill-governed globalized world that is creating health risks that could potentially destabilise the entire enterprise.

The idea by Thai scholar Prawase Wasi, of using a 'triangle which moves the mountain' may be enlightening in this challenge. Wasi argues that addressing major problems (*the mountain*) requires a *triangle* of knowledge, political commitment and social mobilization. The three are mutually reinforcing and enabling.[26] Of the three, political commitment may perhaps pose the biggest hurdle. Politics is often seen as a "dirty word" in health policy, associated with undue interference with "evidence-based" decision making, nepotism and vested, often domineering, self-interests. Such problems, however, are symptoms of present gaps (participatory, jurisdictional and incentive) in global health governance.[27] Without an agreed institutional frameworks, and rules and procedures, to make decisions about collective needs and actions, bad politics will continue to ensue.

This paper concludes that both retirement of the old WHO and its reinvention, as part of effective global health governance, is urgently needed. The current trajectory suggests that WHO and powerful donors will continue their slow dance of death, with the organization becoming increasingly irrelevant and sidelined by other institutional players. The composite of these alternative institutional arrangements, however, fall far short of the coherent, independent and decisive authority needed to meet the collective health needs of a globalized world. WHO's demise, in this respect, would be a tragedy. So would the status quo.

References

1. Lee, K. The World Health Organization. Routledge; London: 2008.
2. Lee, K.; Fang, J. Historical Dictionary of the World Health Organization. 2nd. Scarecrow Press; Lanham MD: 2012.
3. Diouf, J. Statement of the Director-General of the Food and Agriculture Organization. Geneva: 2005. UN Reform – the Specialized Agencies must change too. http://www.fao.org/english/dg/oped/reform.html
4. International Labour Organization. United Nations reform and the International Labour Organization, Questions and Answers. Geneva: 2009. http://www.ilo.org/wcmsp5/groups/public/---dgreports/---exrel/documents/publication/wcms_173313.pdf (accessed 27 March 2013)
5. Godlee F. WHO in retreat: is it losing its influence? BMJ. 1994; 309:1491. [PubMed: 7804058]
6. Vaughan JP, Mogedal S, Kruse SE, LEE K, Walt G, de Wilde K. WHO and the effects of extrabudgetary funds: Is the Organization being donor driven?". Health Policy and Planning. 1996; 1996(3):253–64.
7. Lucas, A.; Mogedal, S.; Walt, G.; Hodne Steen, S.; Kruse, SE.; Lee, K.; Hawken, L. Cooperation for Health Development, The World Health Organisation's support to programmes at country level. Governments of Australia; Canada, Italy, Norway, Sweden and UK, London: 1997.
8. Lerer L, Matsopoulos R. "The Worst of Both Worlds": The Management Reform of the World Health Organization. International Journal of Health Services. 2001; 2001(2):415–438. [PubMed: 11407175]
9. Yamey G. Have the latest reforms reversed WHO's decline? BMJ. 2002; 325(7372):1107–1112. [PubMed: 12424177]
10. Brown T, Cueto M, Fee E. The World Health Organization and the Transition from 'International' to 'Global' Public Health. American Journal of Public Health. 2006; 2006(1):62–72. [PubMed: 16322464]
11. WHO. WHO Response to Global Change. Report of the Executive Board Working Group; Geneva: 1993.
12. Brundtland, GH. Address to Permanent Missions in Geneva. 10 November 1998. https://apps.who.int/director-general/speeches/1998/english/19981110_missions.html (accessed 27 March 2013)
13. WHO. WHO Response to Global Change; 48th World Health Assembly; Geneva. 22 November 1995. http://whqlibdoc.who.int/hq/1995/PPE_95.4.pdf (accessed 27 March 2013)
14. Ruger JP, Yach D. The Global Role of the World Health Organization. Global Health Governance. 2008; 2008(2):1–11.
15. Buse K, Gwin C. The World Bank and global cooperation in health: the case of Bangladesh. Lancet. 1998; 1998(9103):665–669. [PubMed: 9500349]
16. Lee K, Collinson S, Walt G, Gilson L. Who should be doing what in international health: A confusion of mandates in the United Nations?". BMJ. Feb; 1995 312(3):302–307. [PubMed: 8611793]
17. WHO. WHO Reform, Managerial reform: making WHO's financing more predictable; WHO Executive Board, 130th Session, Provisional agenda item 5, EB130/5 Add.5; 2011. 22 December

18. Nebehay, S.; Lewis, B. WHO slashes budget, jobs in new era of austerity. Reuters. May 11. 2011 http://www.reuters.com/article/2011/05/19/us-who-idUSTRE74I5I320110519 (accessed 27 March 2013)
19. Scholte, JA. Globalization, A Critical Introduction. Palgrave; London: 2005.
20. Lee, K. Globalization and Health, An Introduction. Palgrave; London: 2002.
21. Democratizing Global Health Coalition. Time to untie the knots: The WHO reform and democratizing global health, Delhi Statement. May.2011 (accessed 27 March 2013).
22. WHO. Public web consultation on WHO's engagement with non-State actors. Geneva: 2013. http://www.who.int/about/who_reform/governance/who_reform_non_state_actors_consultation_2013.pdf (accessed 27 March 2013)
23. WHO. Constitution of the World Health Organization. Geneva: 1946. Article 1
24. Archibugi, D.; Held, D. Cosmopolitan Democracy: An Agenda for a New World Order. Polity Press; London: 1995.
25. Archibugi, D. The Global Commonwealth of Citizens: Toward Cosmopolitan Democracy. Princeton University Press; Princeton: 2008.
26. Wasi P. "Triangle That Moves The Mountain" and Health Systems Reform Movement in Thailand. Human Resources for Health Development Journal. 2000; 2000(2):106–110.
27. Kaul, I.; Grunberg, I.; Stern, MA., editors. Global Public Goods, International Cooperation in the 21st Century. Oxford University Press; New York: 1999.