

WHO's next? Changing authority in global health governance after Ebola

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We have learned an uncomfortable lesson over the past six months; none of the organisations in the most affected countries [during the 2014 Ebola outbreak]—UN, WHO, local governments, NGOs (including MSF)—currently have the right set-up to respond at the scale necessary to make a serious impact on the spread of the outbreak.

Brice de la Vigne, Head of Operations, Médecins sans Frontières, 28 Aug. 2014¹

This is a defining moment for the health of the global community. WHO must re-establish its pre-eminence as the guardian of global public health; this will require significant changes throughout WHO with the understanding that this involves both the Secretariat and Member States.

Stocking Report, June 2015²

The World Health Organization (WHO), as the lead international institution charged with the promotion and protection of health globally, occupies a central place in the system of global health governance.³ The 2014 Ebola crisis in West Africa, however, elicited widespread and sustained criticism of its performance, leading many to call for its reform and some for its replacement.⁴ A number

* This article originated as a background brief for the High-Level Expert Group on Global Health Emergencies, established in June 2015 to support the 32nd Annual Plenary of the InterAction Council. I would like to thank other members of the group, including its chair HE President Olusegun Obasanjo, for their comments in the subsequent discussion, on which the article draws in part. The article also draws on discussion at the All-Party Parliamentary Group on Global Health's meeting on Ebola in February 2015. Of necessity, comments from both of these meetings are not acknowledged but, where possible, published sources have been used to support them. I would also like to thank Adam Kamradt-Scott for sharing his thoughts on the subject with me, and the two anonymous reviewers for their comments. The title of the article, of course, alludes to the album *Who's Next* (Track Records, 1971) by The Who.

¹ Médecins sans Frontières (MSF), 'Ebola: MSF response to the WHO new Ebola roadmap', 28 Aug. 2014, <http://www.msf.org/article/ebola-msf-response-who-new-ebola-roadmap>, accessed 5 Oct. 2015.

² World Health Organization (WHO), *Report of the Ebola Interim Assessment Panel* (Geneva: WHO, 2015; hereafter Stocking Report), p. 5.

³ See e.g. Kelley Lee, *The World Health Organization* (Abingdon: Routledge, 2009); Jeremy Youde, *Global health governance* (Cambridge: Polity, 2012), esp. pp. 29–45; Sara E. Davies, *Global politics of health* (Cambridge: Polity, 2009), esp. ch. 2; Sophie Harman, *Global health governance* (Abingdon: Routledge, 2012).

⁴ e.g. Jason Gale and John Lauerman, 'Ebola spread over months as WHO missed chance to respond', *Bloomberg Business*, 16 Oct. 2014; 'Reform after the Ebola debacle', op-ed, *New York Times*, 10 Feb. 2015; Stephanie Nebehay, 'Lack of leadership hurts Ebola fight in West Africa', Reuters, 21 Aug. 2014, <http://uk.reuters.com/article/2014/08/21/uk-health-ebola-msf-idUKKBN0GL25320140821>; John Moore, 'Ebola: what lessons for the International Health Regulations?', *The Lancet* online, 8 Oct. 2014, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61697-4/fulltext?rss=yes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61697-4/fulltext?rss=yes); Charles Clift, 'Ebola and WHO reform: who cares?'

of commentators threw the net more widely, suggesting that the problem was systemic rather than related to the effectiveness or otherwise of a single institution;⁵ nevertheless, the WHO became the lightning rod for concerns about the lack of an effective response to a major health crisis.

This article moves on from these initial analyses, which emphasized the WHO's 'failure', to provide a more nuanced account of the WHO's performance and the nature of the proposed reforms. In particular, it goes beyond the focus on specific failings such as poor leadership, lack of funding, and the relationship between the WHO headquarters in Geneva and its regional offices. Rather, using the framework developed by Avant, Finnemore and Sell,⁶ it argues that the crisis has led to a shift in the nature of the WHO's authority as a global governor. As Avant, Finnemore and Sell argue, 'exogenous shocks can certainly change governors and governing arrangements',⁷ and this article suggests that the 2014 West African Ebola outbreak provided just such a shock for the system of global health governance, of which the WHO is the key element. This 'shock' should in fact not have come as a surprise: the SARS epidemic of 2003 and the H1N1 ('swine flu') pandemic of 2009 were at the very least harbingers of a changed exogenous environment. Suggestions that infectious diseases of this virulence posed a novel global risk, which required new global health governance arrangements, held the potential to establish a permissive context for changes to the authority under which global health governors, such as the WHO, operate. As this article suggests, criticisms of the WHO's performance—not only during the 2014 Ebola crisis but during those earlier epidemics as well—reflected not only failings on its part, but also tensions between different forms of authority. Using the terminology established by Avant, Finnemore and Sell, the article argues that the WHO's authority was traditionally based on the 'expert' and 'delegated' models. Despite a number of innovations since the millennium, including an improved disease surveillance and response system through the Global Outbreak Alert and Response Network and revisions to the International Health Regulations (IHRs), the WHO had not been provided with an operational capacity to respond to a major disease outbreak. Nor was the WHO's organizational culture capable of accepting such a role. Rather, its actions during the West African Ebola outbreak remained consistent

Global Health Check, 14 Oct. 2014, <http://www.globalhealthcheck.org/?p=1678>; MSF, 'Ebola: official MSF response to the WHO declaring Ebola an international public health emergency', 8 Aug. 2014, <http://www.msf.org/article/ebola-official-msf-response-who-declaring-ebola-international-public-health-emergency>; MSF, 'Ebola: MSF response to the WHO new Ebola roadmap'; David L. Heymann et al., 'Global health security: the wider lessons from the West African Ebola virus disease epidemic', *The Lancet* 385: 9980, 9 May 2015, pp. 1884–1901, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)60858-3/full-text](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60858-3/full-text); Associated Press, 'Panel blames politics for botched WHO Ebola response', 7 July 2015, <http://www.modernhealthcare.com/article/20150707/NEWS/307079994>. (All URLs accessed 30 Sept. 2015.)

⁵ e.g. Lawrence O. Gostin and Eric A. Friedman, 'A retrospective and prospective analysis of the West African Ebola virus disease epidemic: robust national health systems at the foundation and an empowered WHO at the apex', and David P. Fidler, 'The Ebola outbreak and the future of global health security', both in *The Lancet* 385: 9980, May 2015; MSF, 'Ebola: pushed to the limit and beyond', 23 March 2015, <http://www.msf.org/article/ebola-pushed-limit-and-beyond>, accessed 30 Sept. 2015.

⁶ Deborah D. Avant, Martha Finnemore and Susan K. Sell, eds, *Who governs the globe?* (Cambridge: Cambridge University Press, 2008), esp. pp. 9–14.

⁷ Avant et al., *Who governs the globe?*, p. 3.

with the model of expert and delegated authority. The WHO, however, became the focus for criticism of the handling of the West African Ebola outbreak. This was not simply because it failed to provide sufficiently prompt warning of the developing crisis and to coordinate international response; as the lead governor in global health, it was also implicated in the system's apparent failure to provide an adequate response. Beginning in 2015, reforms at the WHO have attempted to address the issue of an operational capacity to act in major health crises, thereby potentially changing the WHO's authority to one more heavily based on capacity. These reforms are still under way, and the article suggests two 'litmus tests' to identify whether such changes have been embedded in the governance architecture and accepted by both governors and governed.

In the terms used by Avant, Finnemore and Sell, the WHO is a global health governor because it possesses the authority to exercise power over borders for the purposes of affecting policy. In this sense, authority is separate from legitimacy, in that authority creates the basis for deference to a governor's wishes. Legitimacy, however, is created through the establishment of trust in a governor, trust here being understood as governors meeting the expectations of the governed in terms of their behaviour on specific issues. The importance of authority is that it establishes the parameters of a governor's actions—not only what they can or cannot do, but the expectations of what they *should* do given the nature of the authority accorded them. As Avant, Finnemore and Sell state: 'Governors cannot do just anything they want; their actions must be seen by the governed (and others) to accord with whatever authorizes them to act.'⁸ Authority creates expectations of the governor which, when they are not fulfilled, leads to a lack of trust, potentially undermining legitimacy. In their framework, several different types of authority exist for global governors, each suggesting different parameters of action. For the purposes of this article, three are particularly significant: *delegated* authority, where states have 'loaned' to a governor the ability to act in certain areas; *expert* authority, based on the governor's technical expertise; and *capacity-based* authority, based on the governor's ability to undertake effective action. These different forms of authority are not mutually exclusive, and a governor may possess multiple authorities; but when it does so, it runs the risk of conflict between different expectations of behaviour. This may result in a variety of outcomes, ranging from institutional paralysis to the prioritization of one form of authority over another or others. These outcomes in turn affect the legitimacy of governors, potentially creating pressure for change in either a governor's authority, or in who the governors are.⁹

The significance of this framework is that it enables debates on global health governance and institutions such as the WHO to be recast, moving away from questions of the relationship with states and effects on sovereignty towards a richer understanding based on different relationships between global health governors and governed. More specifically, it establishes a means of understanding how

⁸ Avant et al., *Who governs the globe?*, pp. 10–11.

⁹ Avant et al., *Who governs the globe?*, pp. 1–31, 356–70.

the nature of the WHO may be changing. The article argues that the nature of the WHO's authority, which had traditionally been of the expert and delegated type, explains the organization's actions (though not its failures) during the Ebola outbreak, from the distribution of technical guidance to the care exercised over declaring an emergency.¹⁰ The wider expectation of action during the crisis created a tension, which undermined trust in the WHO and threatened its legitimacy.

It is important at this stage to note two key points. First, this expectation of action did not arise particularly from WHO member states—the traditional source of the WHO's authority. Rather, it arose from a wider community, including civil society, NGOs, charities and the media, which increasingly takes an interest in global health and provides additional sources of authority and legitimacy. The article therefore differentiates between WHO member states, which comprise the WHO's World Health Assembly and provide its funding, and the 'global community', which includes not only WHO member states but these additional interested bodies.¹¹ Second, the article does not suggest that, for the WHO, capacity-based authority has replaced expert and delegated authority; rather, it suggests that the Ebola crisis has shifted the balance between these elements to place greater emphasis on the former at the expense of the latter two, and that the balance may shift back again once the immediacy of the crisis recedes.

The article's theoretical basis lies in social constructivism.¹² In particular, it is based on the idea that the social world does not exist independently of observation, but rather that the material and ideational worlds are mutually constitutive. This is important for the analysis below because it suggests that what is said both reveals and constructs understandings of the social world. The analysis therefore does not suppose an independent reality against which the WHO's performance can be judged and lessons learned; rather, it uses the criticisms and explanations of the WHO's actions to reveal understandings of its role and the nature of its authority.

¹⁰ Indeed, there are suggestions that the WHO was placed under political pressure by certain member states not to declare a Public Health Emergency of International Concern (PHEIC) earlier. See Lawrence O. Gostin, 'The future of the World Health Organization', *Milbank Quarterly* 93: 3, Sept. 2015, pp. 475–9, <http://www.milbank.org/the-milbank-quarterly/search-archives/article/4046/the-future-of-the-world-health-organization-lessons-learned-from-ebola>, accessed 31 Sept. 2015. During the 2009 H1N1 pandemic, the WHO had been extensively criticized for exceeding its delegated authority in its decision-making procedures and for lack of transparency. See Report of the Health and Social Affairs Committee of the European Council Parliamentary Assembly, *The handling of the H1N1 pandemic: more transparency needed*, 24 June 2010; European Parliament Environment, Public Health and Food Safety Committee, *Report on the evaluation of the management of H1N1 influenza in 2009–10 in the EU*, 2 Feb. 2011; Tine Hannrieder and Christian Kreuder-Sonnen, 'WHO decides on the exception? Security and emergency governance in global health', *Security Dialogue* 45: 4, Dec. 2014, pp. 331–48; Abigail C. Desham, 'Horizontal review between international organizations: why, how and who cares about corporate regulatory capture', *European Journal of International Law* 22: 4, Dec. 2011, pp. 1089–1113.

¹¹ A wide variety of works discuss the changing 'architecture' of global health, though they rarely do so in terms of governors and governed. See e.g. Andrew F. Cooper and John Kirton, eds, *Innovation in global health governance* (Farnham: Ashgate, 2009), esp. pp. 155–244; Davies, *Global politics of health*; Harman, *Global health governance*.

¹² An increasing number of works in global health politics use social constructivism. See e.g. Sara E. Davies, Adam Kamradt-Scott and Simon Rushton, *Disease diplomacy* (Baltimore: Johns Hopkins University Press, 2015); Jeremy Shiffman, 'A social explanation for the rise and fall of global health issues', *Bulletin of the World Health Organization* 87: 8, Aug. 2009, pp. 608–13; Colin McInnes and Kelley Lee, eds, *Global Public Health special supplement 7: SS2, Framing Global Health*, Dec. 2012.

The article begins by outlining the Ebola crisis and articulating the criticisms made of the WHO. It moves on to examine how the WHO explained its performance, and also how it suggested reforms capable of evolving its authority and thereby re-establishing trust in the organization. Although these reforms have been endorsed by the WHO's member states, what Fidler refers to as 'political elasticity'¹³ may lead to pressures to return to a more traditional form of expert and delegated authority. The article therefore identifies two possible litmus tests for the shift away from expert and delegated and towards capacity-based authority.

The West African Ebola outbreak

The outbreak of Ebola in West Africa was the most severe on record.¹⁴ By the beginning of June 2015, the WHO estimated that there had been 27,181 cases and 11,162 deaths, more than in all of the previous outbreaks of the disease combined.¹⁵ Almost all of these were in the three West African states of Guinea, Liberia and Sierra Leone.¹⁶ The outbreak was subsequently traced back as far as the death of a two-year-old in Meliandou, Guinea, in early December 2013, though the investigators concluded that this was probably not the originating case.¹⁷ In March 2014, hospital staff in Guinea began to notice unusual cases of a fatal disease in the south-east of the country. This was confirmed as Ebola by Guinean health officials and reported by the WHO on 25 March. Earlier that same week, MSF had established its first Ebola clinic in West Africa, beginning a major commitment by the charity to the region. Over the following weeks, the disease began to spread to the two neighbouring West African states of Liberia and Sierra Leone, and to major cities (including capitals) in all three countries; this is unusual for Ebola, which is normally confined to rural regions, and therefore triggered increased concerns over its possible spread through the populations of the countries affected. At a Geneva press conference in April, the WHO described the outbreak as 'one of the

¹³ Fidler, 'The Ebola outbreak and the future of global health security'.

¹⁴ This chronology is constructed using a variety of sources and triangulating where possible. Key sources are reports and updates from the WHO, MSF, US Centers for Disease Control and Prevention (CDC), along with media reports from the BBC, CBS, CNN and Reuters. Timelines constructed by the BBC and CNN are generally accurate when triangulated with other sources; that on Wikipedia is detailed, accurate and clearly sourced; and Breaking News provides a good summary of key events from multiple sources. See BBC News, 'Ebola: mapping the outbreak', <http://www.bbc.co.uk/news/world-africa-28755033>; CNN, 'Ebola fast facts', <http://edition.cnn.com/2014/04/11/health/ebola-fast-facts/>; Wikipedia, 'Ebola virus epidemic in West Africa timeline', http://en.wikipedia.org/wiki/Ebola_virus_epidemic_in_West_Africa_timeline; Breaking News, 'Ebola outbreak 2014–15', <http://www.breakingnews.com/topic/africa-ebola-outbreak-2014/> (all URLs accessed 30 Sept. 2015). I use the term 'West African [Ebola] outbreak' rather than '2014 outbreak' since the outbreak began in 2013 and continued into 2015, and a second, unrelated, outbreak of Ebola occurred in the Democratic Republic of the Congo also in 2014.

¹⁵ WHO, 'Ebola situation report, 3 June 2015', <http://apps.who.int/ebola/ebola-situation-reports>. Comparison made using data from the WHO for the West African outbreak and US CDC for previous outbreaks. See WHO, 'Current context and challenges; stopping the epidemic; and preparedness in non-affected countries and regions', paper prepared for WHO Executive Board Special Session on Ebola, EBSS/3/2, http://apps.who.int/gb/e/e_ebs3.html, para. 19; US CDC, 'Outbreaks chronology: Ebola virus disease', 4 March 2015 update, <http://www.cdc.gov/vhf/ebola/outbreaks/history/chronology.html>. (All URLs accessed 30 Sept. 2015.)

¹⁶ WHO, 'Ebola situation report'.

¹⁷ Sylvain Baize et al., 'Emergence of Zaire Ebola virus disease in Guinea', *New England Journal of Medicine* 371: 15, Oct. 2014, pp. 1418–25.

most challenging ... that we have ever faced'.¹⁸ In June the WHO declared the outbreak a grade 3 emergency, the highest level possible, while MSF (who by then were heavily involved on the ground) warned that the disease was out of control.¹⁹ By July a range of social distancing measures had been introduced in the three West African states most severely affected, including school closures, curfews and limits on border crossings; by the end of that month, the first cases were being reported in Nigeria.²⁰ In late July and early August, two US aid workers infected with Ebola—Kent Brantly and Nancy Writebol—were airlifted to the United States, beginning a small but steady flow of medical evacuations for infected health workers back to America or Europe. Reports suggested that Brantly and Writebol had been treated in West Africa with an experimental drug, ZMapp, beginning a debate over the ethics and feasibility of rapid development and fast tracking of vaccines. On 8 August, for only the third time in its history, the WHO declared the outbreak a Public Health Emergency of International Concern (PHEIC) under the 2005 revisions to the IHRs. On 14 August it announced that field reports might have underestimated the severity of the outbreak, and on 28 August it released its 'roadmap' to coordinate the international response.

In September, with numbers of deaths still rising, the UN Security Council passed Resolution 2177, declaring the outbreak a threat to international peace and security, and the General Assembly authorized the Secretary General's request for the establishment of the UN Mission for Emergency Ebola Relief (UNMEER). MSF's earlier warning that the disease was out of control in West Africa appeared to be supported by an estimate from the US Centers for Disease Control and Prevention (CDC) at the end of September that by January 2015 the number of cases in Liberia and Sierra Leone might exceed 1.4 million.²¹ On 30 September, CDC named Thomas Edward Duncan as the first case of Ebola identified within the United States, quickly followed by two further cases involving medical workers treating Duncan. This led to concerns over the ability of the United States to contain the disease—concerns echoed in Europe when a nursing assistant, Maria Teresa Romero Ramos, was also diagnosed as having caught the disease while working at a hospital in Spain. With the disease spreading—albeit slowly—to Europe and North America, and established methods of control appearing to fail, WHO Director-General Margaret Chan commented: 'In my long career in public health ... I have never seen a health event strike such fear and terror, well beyond

¹⁸ WHO, 'Key events in the WHO response to the Ebola outbreak', Jan. 2015, <http://www.who.int/csr/disease/ebola/one-year-report/who-response/en/>, accessed 30 Sept. 2015.

¹⁹ WHO, 'Key events'; MSF, 'Ebola in West Africa: epidemic requires massive deployment of resources', 21 June 2014, <http://www.msf.org/article/ebola-west-africa-epidemic-requires-massive-deployment-resources>, accessed 30 Sept. 2015.

²⁰ The Nigerian Ministry of Health reported a total of 19 confirmed cases and one suspected case between 31 July and 8 September. Senior Nigerian sources attribute the control of the outbreak there to prompt and effective action by the Nigerian authorities.

²¹ US CDC, 'Estimating the future number of cases in the Ebola epidemic', 19 Nov. 2014, <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/qa-mmwr-estimating-future-cases.html>. See also Maximilian Haeussler et al., 'The UCSC Ebola genome portal', *PLoS Currents*, online, 7 Nov. 2014, <http://currents.plos.org/outbreaks/article/the-ucsc-ebola-genome-portal/> (both accessed 30 Sept. 2015).

the affected countries.²² By this time, world leaders were queueing up to express their concern, offer aid and, in a limited number of cases, dispatch troops to assist in the aid effort—although not without criticism that words were not always matched by deeds.²³ At the end of 2014, rates of new infection were slowing, and in January the outbreak appeared to be in decline. Even so, by September 2015, small numbers of cases were still presenting in both Sierra Leone and Guinea.

WHO's to blame?

The WHO describes its role in respect of this disease as

to prevent Ebola outbreaks by maintaining surveillance for Ebola virus disease and supporting at-risk countries to develop preparedness plans ... When an outbreak is detected WHO responds by supporting surveillance, community engagement, case management, laboratory services, contact tracing, infection control, logistical support and training and assistance with safe burial practices.²⁴

This passage reveals an understanding of the WHO as a body offering technical support rather than being operationally engaged, an understanding which was regularly articulated by Margaret Chan during the crisis, along with statements that governments, not the WHO, had first responsibility for taking care of patients.²⁵ Nor were Chan and her colleagues in the WHO Secretariat alone in this view of the Organization. Kelley Lee, in a leading textbook on the WHO, describes its core functions as providing leadership; shaping the research agenda and stimulating the exchange of knowledge; setting norms and standards; articulating ethical and evidence-based policy options; providing technical support; and monitoring the health situation and trends.²⁶ The operational ability to act in a crisis is noticeable by its omission.

The recent Ebola outbreak in West Africa, however, led to 'blistering' criticism of the WHO.²⁷ Ebola was 'the Hurricane Katrina for the World Health

²² Margaret Chan, 'WHO Director-General's speech to the Regional Committee for the Western Pacific', 13 Oct. 2014, <http://who.int/dg/speeches/2014/regional-committee-western-pacific/en/>, accessed 30 Sept. 2015. See also Jeremy J. Farrar and Peter Piot, 'The Ebola emergency: immediate action, ongoing strategy', *New England Journal of Medicine* 371: 14, Oct. 2014, pp. 1545–6.

²³ WHO, 'Current context and challenges', para. 8. See also Kim Yi Dionne, 'Obama's Ebola failure', *Foreign Affairs*, 15 Sept. 2014, <https://www.foreignaffairs.com/articles/africa/2014-09-15/obamas-ebola-failure>; Matthew Holehouse, 'David Cameron rounds on European leaders who spend less fighting Ebola than Ikea', *Daily Telegraph*, 23 Oct. 2014, <http://www.telegraph.co.uk/news/worldnews/ebola/11183784/David-Cameron-rounds-on-European-leaders-who-spend-less-fighting-Ebola-than-Ikea.html> (both accessed 30 Sept. 2015).

²⁴ WHO, 'Ebola virus disease', fact sheet 103, Aug. 2015 update, <http://www.who.int/mediacentre/factsheets/fs103/en>, p. 4, accessed 30 Sept. 2015.

²⁵ Margaret Chan, 'Report by the Director-General to the Special Session of the Executive Board on Ebola', 25 Jan. 2015, <http://www.who.int/dg/speeches/2015/executive-board-ebola/en/>, accessed 30 Sept. 2015; WHO, 'Current context and challenges', esp. para. 23; Lawrence O. Gostin, 'World Health Organization reform: lessons learned from the Ebola epidemic', *The Hastings Center Report* 45: 2, March–April 2015, pp. 6–7.

²⁶ Lee, *The World Health Organization*, p. 20. See also Margaret Reeves and Suzanne Brundage, *Leveraging the World Health Organization's core strengths* (Washington DC: Center for Strategic and International Studies, 2011); Jennifer P. Ruger and Derek Yach, 'Global functions at the World Health Organization', *British Medical Journal* 330: 7500, May 2005, pp. 1099–1100, and 'The global role of the World Health Organization', *Global Health Governance* 2: 2, April 2009, pp. 1–11.

²⁷ Madison Park, 'WHO announces changes after widespread Ebola criticism', CNN online, 18 May 2015, <http://edition.cnn.com/2015/05/18/health/who-ebola-reform/>, accessed 30 Sept. 2015.

Organization—its moment of failure’.²⁸ As MSF’s Bart Janssen bluntly commented: ‘Lives are being lost because the response is too slow.’²⁹ (In stark contrast, the performance of MSF was widely praised, not least for its prompt action.³⁰) The *New York Times*’ use of the term ‘debacle’ and its description of the WHO’s performance as ‘anemic’ were typical.³¹ Critics blamed poor leadership and weak management. Director-General Margaret Chan was seen as initially dismissive of the problem and then keen to pass blame onto national authorities or the global community, while individuals in the WHO’s Africa Regional Office (AFRO) were also identified, individually or collectively, as demonstrating little competence and appearing more concerned with reputational risk and trade protection than saving lives.³² Critics also identified organizational failings. Ilona Kickbusch, subsequently appointed to the panel set up under Dame Barbara Stocking to assess the WHO’s response to the crisis,³³ commented that the Organization was ‘caught in political gridlock’.³⁴ The respected health commentator Charles Clift argued that the outbreak had ‘revealed deficiencies in [the WHO’s] performance’, a sentiment echoed in the Stocking Report’s subsequent conclusion that ‘the Ebola crisis ... exposed organizational failings in the functioning of WHO’.³⁵

Underpinning these criticisms is a belief that the WHO did too little too late, especially in warning of the potential severity of the outbreak and in providing

²⁸ Jason Beaubien, ‘Critics say Ebola crisis was WHO’s big failure: will reform follow?’, NPR, 6 Feb. 2015, <http://www.npr.org/sections/goatsandsoda/2015/02/06/384223023/critics-says-ebola-crisis-was-whos-big-failure-will-reform-follow>, accessed 30 Sept. 2015.

²⁹ MSF, ‘Ebola: official MSF response to the WHO declaring Ebola an international public health emergency’.

³⁰ This appreciation was reflected in the inclusion of MSF’s international president, Joanne Liu, in *Time* magazine’s 2015 list of the top 100 most influential people, among ‘leaders’. The commendation, written by the head of the US CDC Tom Frieden, stated: ‘Liu repeatedly got it right, and MSF was at the right places at the right times ... MSF was right when it sounded the alarm about the unprecedented spread of ebola. And it was right in sounding the alarm for increased global action ... she charged—and continues to charge—the world to better respond to crises’: Tom Frieden, ‘Joanne Liu: crusader for global health’, <http://time.com/3822834/joanne-liu-2015-time-100/>. See also House of Commons International Development Committee, *Responses to the Ebola crisis*, 8th Report of Session 2014–15, 15 Dec. 2014, <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmintdev/876/876.pdf>; Anna Petherick, ‘Ebola in west Africa: learning the lessons’, *The Lancet* online, 10 Feb. 2015, <http://ebola.thelancet.com/pb/assets/raw/Lancet/pdfs/S0140673615600757.pdf>. (All URLs accessed 30 Sept. 2015.)

³¹ ‘Reform after the Ebola debacle’, *New York Times*. See also House of Commons, *Responses to the Ebola crisis*; ‘Lack of leadership hurts Ebola fight in West Africa’, Reuters; ‘WHO leadership admits failings over Ebola, promises reform’, Reuters, 19 April 2015, <http://www.reuters.com/article/2015/04/19/us-health-ebola-who-idUSKBN0NA12J20150419>; MSF, ‘Ebola: pushed to the limit and beyond’; Joanne Liu, ‘United Nations special briefing on Ebola’, 2 Sept. 2014, <http://www.msf.org.uk/article/msf-international-president-united-nations-special-briefing-ebola>; John Moore, ‘Ebola: what lessons for the International Health Regulations?’, *The Lancet* 384: 9951, Oct. 2014, p. 1321; Gostin and Friedman, ‘A retrospective and prospective analysis of the West African Ebola virus disease epidemic’; Fidler, ‘The Ebola outbreak and the future of global health security’. (All URLs accessed 30 Sept. 2015.)

³² Adam Kamradt-Scott, ‘WHO’s to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa’, unpublished manuscript June 2015; Beaubien, ‘Critics say Ebola crisis was WHO’s big failure’. The Stocking Report (p. 18) notes that, while some of the criticism of AFRO may have been justified, it lacked capacity after budget cuts between 2011 and 2013 reduced its core staff to fewer than ten people for the entire region.

³³ The panel was established at the request of the WHO Executive Board in its January 2015 special meeting on Ebola. Although panel members were independent of the WHO, their appointment by the organization has led to some questions over its degree of independence.

³⁴ Ilona Kickbusch, ‘Global health security: a cosmopolitan moment?’, G7G20, <http://www.g7g20.com/articles/ilona-kickbusch-global-health-security-a-cosmopolitan-moment>, accessed 30 Sept. 2015.

³⁵ Clift, ‘Ebola and WHO reform: who cares?’; Stocking Report, p. 5.

leadership in the response. For example, even though the WHO had publicized the outbreak in March 2014, and in April described it as ‘one of the most challenging’ outbreaks of the disease ever faced, in subsequent weeks it did little to raise concerns as the numbers of cases increased and the disease spread into neighbouring states.³⁶ As Chan and senior colleagues at the WHO subsequently admitted:

The initial response was slow and insufficient, we were not aggressive in alerting the world, our surge capacity was limited, we did not work effectively in coordination with other partners, there were shortcomings in risk communications, and there was confusion of roles and responsibilities at the three levels of the Organization.³⁷

Particular criticism focused on the WHO’s unwillingness to declare a PHEIC and thereby galvanize a global response. Using leaked documents, the Associated Press reported that the WHO was aware of the rapidly worsening situation over the summer of 2014, but resisted calling a PHEIC for political and economic reasons; in particular, concern about the risks of harming relations with the affected countries, not least because of the possible impact of any such declaration on their fragile economies. The AP reported MSF’s International President Joanne Liu telling Margaret Chan at a meeting in Geneva in July 2014 to ‘step up to the plate’ and demonstrate greater leadership.³⁸ In April 2015 Chan, together with other senior WHO officials, publicly spoke of having to learn ‘lessons in humility’, admitting that they ‘had not coped’ with the Ebola outbreak and needed to take ‘serious note of the criticisms of the Organization’.³⁹ MSF’s early warnings of an impending disaster appeared to stand in stark contrast to the WHO’s caution. If the WHO’s authority was based on its ‘expert’ status, then it was roundly criticized for failing in this, with the result that trust in the Organization was compromised and its legitimacy questioned.

The WHO’s emphasis upon expert authority during the crisis was reflected in the Stocking Report’s analysis of its performance during the West African Ebola outbreak. The report suggests that the culture at the WHO was not conducive to risk-taking and prompt action: ‘WHO does not have a culture of rapid decision-making and tends to adopt a reactive, rather than a proactive, approach to emergencies.’⁴⁰ This again reflects the organization’s role as provider of expert technical advice, a role in which it is more important to be correct than prompt, and in which its normative power arises in no small part from the quality of the advice it provides. As the Stocking Report continues, however: ‘When a health emergency occurs, there must be an ability to shift into rapid decision-making and action.’⁴¹ It

³⁶ Kamradt-Scott, ‘WHO’s to blame?’.

³⁷ Margaret Chan and others (unnamed), ‘Joint statement on the Ebola response and WHO reforms’, UN Information Centre, Canberra, 20 April 2015, <http://un.org.au/2015/04/20/joint-statement-on-the-ebola-response-and-who-reforms/>, accessed 30 Sept. 2015.

³⁸ Associated Press (AP), ‘Political considerations delayed WHO Ebola response, emails show’, available through CBS News at <http://www.cbsnews.com/news/political-considerations-delayed-who-ebola-response-emails-show/>, 20 March 2015, accessed 30 Sept. 2015.

³⁹ Chan and others, ‘Joint statement’.

⁴⁰ Stocking Report, p. 12.

⁴¹ Stocking Report, p. 17.

is here that the Organization fell short: 'WHO has a technical, normative culture, not one that is accustomed to dealing with such large-scale, long-term and multi-country emergency responses occurring at the same time or that is well-suited to challenging its Member States.'⁴² Indeed, the WHO was praised by regional governments in West Africa for the quality of its technical support, while its reluctance to act independently was noted in criticisms from NGOs that it was too close to governments.⁴³ Nor did the WHO have the finances or capacity to mount a major operation in West Africa. Not least, its core budget had been progressively cut in real terms since 2008, while the somewhat byzantine method by which it is funded—less than a quarter of its budget is under the Organization's control, the remainder being spent on programmes specified by member states—meant that it had insufficient financial discretion to fund a crisis response.⁴⁴ Moreover, the Ebola outbreak was not the only major health crisis the WHO was managing within this limited budget. In addition to the four other grade 3 emergencies it was involved in during the summer of 2014, the WHO had declared only the second PHEIC in its history over the major outbreak of polio in Syria in April 2014 (just a few days after publicly identifying the outbreak of Ebola in Guinea).⁴⁵ On the basis of the Stocking Report, then, the problem may be seen (using Avant, Finnemore and Sell's framework) as not simply one of a failure to implement its expert authority, but also one of whether it should have a capacity-based authority equipping it to exercise a more operational role in such large-scale crises.

Shifting the balance of the WHO's authority

The WHO offered its own account of its actions, notably in a series of documents prepared for the Special Session of the WHO's Executive Board on Ebola in January 2015,⁴⁶ and then for the May 2015 World Health Assembly.⁴⁷ These reveal an understanding of its authority as primarily expert and delegated. This is seen most clearly in its emphasis on protocol-based action, following established guidelines for action based either on public health methodologies or on established procedures, rather than on seizing the initiative and acting in a decisive manner. The WHO narrative explains the delays in identifying the outbreak in terms of initially incorrect diagnoses by local medics, unfamiliar with the disease—not least because Ebola had not appeared previously in West Africa. In particular,

⁴² Stocking Report, p. 13.

⁴³ Stocking Report, p. 19.

⁴⁴ Stocking Report, pp. 16, 21. See also Clift, 'Ebola and WHO reform: who cares?'; Lee, *The World Health Organization*, pp. 38–44.

⁴⁵ WHO, 'Key events'; WHO, *WHO response in severe, large-scale emergencies*, Report of the Director-General to the 68th World Health Assembly, A68/23, 15 May 2015, http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_23-en.pdf, accessed 30 Sept. 2015.

⁴⁶ In addition to the agenda, members of the Executive Board received two supporting papers and five information documents for the Special Session, all of which are available at http://apps.who.int/gb/e/e_ebss3.html, accessed 30 Sept. 2015.

⁴⁷ See esp. *WHO response in severe, large-scale emergencies*; WHO, '2014 Ebola virus outbreak', paper A68/24 for 68th World Health Assembly, 15 May 2015.

diagnoses of cholera and Lassa fever were made, rather than of Ebola.⁴⁸ The WHO nevertheless responded in March 2015—the same month as MSF began to publicly alert the global community to the outbreak—by declaring a grade 2 emergency and dispatching a small number of staff to the region to investigate further and offer technical support. Adam Kamradt-Scott argues that,

while the WHO's response was extensively criticized by Médecins sans Frontières for its perceived lack of action throughout this [early] period, given the number of suspected cases and deaths were consistent with the size of previous [Ebola] outbreaks in other parts of Africa, it would be unreasonable to suggest that the WHO secretariat had been negligent.⁴⁹

In other words, the WHO was following established protocols based on a technical understanding of the problem.

The WHO's explanation continues by pointing out that it was only in the second half of June that it became clear that this episode was more serious than previous outbreaks. Indeed, for a short time previously, cases in Guinea (at that time the most seriously affected state) had been falling, in line with the pattern from previous outbreaks, suggesting that the worst might be over. The WHO responded by calling a grade 3 emergency in July, followed by the declaration of a PHEIC in August. It also attempted to mobilize and coordinate the international response by publishing a 'roadmap' in late August.⁵⁰ The WHO argued that it played a key role in mobilizing and coordinating the response within West Africa—especially the technical response—at local, national and international levels. This included publishing 45 technical guidance documents, hosting a series of meetings on the ethical use and clinical testing of non-registered vaccines and blood products for treating Ebola, and developing improved diagnostic tools. Moreover, it played a major role in expanding clinical, public health and laboratory services in the three most badly affected countries, with more than 700 WHO staff members and 2,100 technical experts deployed by April 2015 across more than 60 field sites in Guinea, Liberia and Sierra Leone, as well as smaller numbers in neighbouring countries. This represented the largest emergency operation in the Organization's history.⁵¹ Finally, the WHO played a key role in preparedness planning to prevent the further spread of the outbreak, including sending 14 assessment missions to other at-risk countries, while also introducing temporary restrictions under the terms of the IHRs.

What is striking in the WHO's account, most of which originated in the Geneva secretariat, is its close fit with an understanding of the WHO as believing

⁴⁸ WHO, 'Current context and challenges', para. 4.

⁴⁹ Kamradt-Scott, 'WHO's to blame?'. AP, however, reported concerns that some of the WHO staff dispatched to West Africa were poorly trained for and lacked experience of Ebola: AP, 'Political considerations'.

⁵⁰ WHO, 'Current context and challenges'.

⁵¹ WHO response in severe, large-scale emergencies, esp. paras 30 and 32; WHO, 'Highlight of efforts made to date towards preparing non-affected countries and regions to respond to potential importation of EVD', paper EB136/INF./3 for the Special Session of the Executive Board on the Ebola Emergency, 9 Jan. 2015; WHO, 'Fast tracking the development and prospective roll-out of vaccines, therapies and diagnostics in response to Ebola virus disease', paper EB136/INF./1 for the Special Session of the Executive Board on the Ebola Emergency, 9 Jan. 2015.

the nature of its authority to be expert and delegated. The WHO presents a narrative that it *did* act, by providing advice and guidance. Indeed, the Stocking Report argues that in some areas it was praised for what it did, not least in providing advice to other states in the region on preventing the spread of the outbreak and its work in protocols for fast-tracking vaccine trials and diagnostic tests.⁵² But these documents also reveal a growing sense within the Organization of a shift being required towards a greater emphasis on capacity, not least in proposals put to the Executive Board in January 2015 to develop an operational capacity for major health crises.⁵³ This suggests not only that the WHO was capable of evolving, but that multiple conceptions of authority were coexisting within the Organization.

Whereas for some the problem was the WHO's inability to implement its expert authority in providing timely warning of crisis, the Organization itself, in reporting both to the Executive Board and to the World Health Assembly, was arguing for a shift in the balance of its authority. In so doing, it was not only commenting on the shortcomings of its performance during the West African Ebola outbreak, but also (more implicitly) reflecting two broad narratives, both of which had been developing to the point of orthodoxy since the new millennium. The first was that, in the words of a British cross-departmental white paper, 'health is global'.⁵⁴ In particular, outbreaks of infectious diseases such as pandemic influenza, SARS and Ebola are likely to spread further and more quickly because of the manner in which globalization has increased the number and intensity of transnational interactions.⁵⁵ The second was that infectious disease outbreaks were likely to be more common because of changes in both the social and the natural worlds. These included urbanization and environmental change, leading to fears of increased vulnerability to (sometimes novel) zoonotic diseases. In this respect, the 2002–2003 epidemic of a novel zoonotic coronavirus, SARS, appeared to be 'a warning'.⁵⁶ This narrative had led not only to ideas of global health security being

⁵² Stocking Report, p. 19.

⁵³ See esp. 'Ensuring WHO's capacity to prepare for and respond to future large-scale and sustained outbreaks and emergencies', Report by the [WHO] Secretariat for WHO Executive Board Special Session on Ebola, EB136/49, 9 Jan. 2015, http://apps.who.int/gb/e/e_ebss3.html; WHO, '2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on Ebola: outcome of drafting group', paper A68/A/CONF./5 for the 68th World Health Assembly, 23 May 2015.

⁵⁴ Department of Health (UK), *Health is global: a UK government strategy 2008–13* (London: The Stationery Office, 2008). See also Kelley Lee, *Globalisation and health: an introduction* (Basingstoke: Palgrave Macmillan, 2003); Davies, *Global politics of health*; Geoffrey B. Cockerham and William C. Cockerham, *Health and globalisation* (Cambridge: Polity, 2010).

⁵⁵ One of the first papers to make this case came from the influential US Institute of Medicine: *America's vital interest in global health* (Washington DC: National Academy Press, 1997). Other key early works in establishing this idea within an academic International Relations context were Lee, *Globalization and health*, and Andrew Price-Smith, *Health of nations* (Cambridge, MA: MIT Press, 2002). See also Sara Davies, 'Securitizing infectious disease threats', *International Affairs* 84: 2, March 2008, pp. 295–313.

⁵⁶ Elizabeth M. Prescott, 'SARS: a warning', *Survival* 45: 3, Autumn 2003, pp. 207–26. Examples of this developing consensus from late in the last century and early in this one are: Jennifer Brown and Peter Chalk, *The global threat of new and re-emerging infectious diseases* (Santa Monica, CA: RAND, 2003); Rohit Burman, Kelly Kirschner and Elissa McCarter, *Infectious disease as a global security threat*, Report for the Environmental Change and Security Program, Washington DC (1997), <http://www.isn.ethz.ch/Digital-Library/Publications/Detail/?lang=en&id=136192>.

at risk from infectious disease,⁵⁷ but also to the thought that global health governance needed to change in response.⁵⁸ The West African Ebola outbreak appeared to demonstrate the inability of global health governors to act to preserve global health security. This opened up a space where not only could the argument for an increased operational capacity be made, but a more fundamental shift in the nature of the WHO's authority could be envisaged.

Shifting the balance of the WHO's authority from the expert and delegated model to a capacity-based model, however, has not been a straightforward matter of the Organization asking and the global community providing. The picture is more complex. Avant, Finnemore and Sell point out that multiple authorities can lead to tensions in global governors;⁵⁹ in the case under consideration here, the present article suggests that tensions appear to have been in existence between a global health governor (the WHO) and its member states for at least a decade prior to the West African Ebola outbreak. In the wake of the more proactive leadership role played by the WHO during the SARS crisis, David Fidler argued that global health had reached a post-Westphalian moment, where international organizations such as the WHO could override narrow state interests and act for the global good in health crises.⁶⁰ This suggested that the crisis had seen a shift for the WHO away from delegated authority. The response by member states, however, despite initially praising the WHO for its handling of the crisis, was to express concern that it had exceeded its mandate. Moreover, although the subsequent revisions to the IHRs (concluded in 2005) enhanced the WHO's ability to act in crises, they also limited its role to offering technical assistance.⁶¹ Similarly, after the 2009 H1N1 ('swine flu') pandemic, concerns were raised over the WHO acting outside the protocols implied by delegated authority.⁶² Further, in the aftermath of that pandemic, proposals from the WHO that it be given a more operational role in health emergencies and a crisis budget of US\$100 million had been turned down by member states.⁶³ Instead, the WHO was criticized for displaying 'competencies

⁵⁷ The nature of the risk was, of course, dependent upon ideas about what global health security was, which were and remain contested. For a thorough examination of the differing accounts of global health security, see Simon Rushton and Jeremy Youde, eds, *Routledge handbook of global health security* (Abingdon: Routledge, 2015).

⁵⁸ See e.g. Youde, *Global health governance*; Kelley Lee and Jeff Collin, eds, *Global change and health* (Milton Keynes: Open University Press, 2005); Cockerham and Cockerham, *Health and globalisation*; Davies, *Global politics of health*.

⁵⁹ Avant et al., *Who governs the globe?*, p. 19.

⁶⁰ David P. Fidler, 'SARS: political pathology of the first post-Westphalian pathogen', *Journal of Law, Medicine and Ethics* 31: 4, Dec. 2003, pp. 485–505.

⁶¹ Adam Kamradt-Scott, *Managing global health security: the World Health Organization and disease outbreak control* (Basingstoke: Palgrave Macmillan, 2015), esp. pp. 116–23; A. P. Cortell and S. Petersen, 'Dutiful actors, rogue agents or both? Staffing, voting rules and slack in the WHO and WTO', in D. G. Hawkins, D. A. Lake, D. L. Nielsen and M. J. Tiernay, eds, *Delegation and agency in international organizations* (Cambridge: Cambridge University Press, 2006), pp. 255–80.

⁶² European Council Parliamentary Assembly, *The handling of the H1N1 pandemic*; European Parliament, *Report on the evaluation of the management of H1N1 influenza*; Hannrieder and Kreuder-Sonnen, 'WHO decides?'; Desham, 'Horizontal review between international organizations'; Deborah Cohen and Philip Carter, 'WHO and the pandemic flu "conspiracies"', *British Medical Journal* 340: c2912, June 2010, pp. 1274–9.

⁶³ WHO, 'The warnings the world did not heed', Jan. 2015, <http://www.who.int/csr/disease/ebola/one-year-report/ihr/en/>, accessed 30 Sept. 2015; Fidler, 'The Ebola outbreak and the future of global health security'; AP, 'Political considerations'. The recommendations are reprinted as an annex to the Stocking Report.

that were of far greater consequence than a vision of a toothless United Nations bureaucracy would have us assume'.⁶⁴ Furthermore, there are suggestions that member states' concerns over the more interventionist approach of the WHO Director-General during the SARS crisis, Gro Harlem Brundtland, led to the appointment of successive directors-general who were much less likely to adopt a similar approach to future crises and were of a more technocratic nature, reinforcing the model of delegated and expert authority.⁶⁵ This suggests that for much of the decade previous to the West Africa Ebola outbreak, at the same time as a consensus was developing that new risks required new forms of global health governance, member states continued to hold a view that the WHO's authority should remain primarily delegated and expert. In this respect, member states do not appear to be unitary actors with a shared understanding of global health governance, but more complex political entities where competing views may be held simultaneously. The implication of the Ebola crisis is that a tipping point was reached, where capacity-based authority assumed greater significance for the global community, but where an adherence to expert and delegated authority also persisted (not least in the eyes of member states).

Meet the new boss, same as the old boss?⁶⁶

Unsurprisingly, perceptions of the WHO's weak performance during the West African Ebola outbreak led to calls for its reform.⁶⁷ As Lee and Pang note, reform of the WHO is a perennial subject of discussion within the global health community.⁶⁸ Indeed, at the time of the Ebola outbreak the WHO was already in the midst of a reform process, begun by the Director-General in 2011 following the global economic downturn of 2008 and reduced contributions to the WHO's budget. Initially focusing on finance, by early 2014 its scope had expanded to three 'themes' of governance, management and programmatic reform.⁶⁹ The West

⁶⁴ Hanrieder and Kreuder-Sonnen, 'WHO decides?', p. 332. Prominent among the critics was the EU: see European Council Parliamentary Assembly, *The handling of the H1N1 pandemic*; European Parliament, *Report on the evaluation of the management of H1N1 influenza*. Although, as Kittelsen argues, many of the latter report's arguments were questionable, it does reflect a predisposition towards delegated authority rather than capacity: Sonja Kittelsen, 'The EU and the securitization of pandemic influenza', PhD diss., Aberystwyth University, 2013, http://cadair.aber.ac.uk/dspace/bitstream/handle/2160/13193/kittelsen_s.pdf?sequence=2&isAllowed=y, accessed 30 Sept. 2015.

⁶⁵ Interview with former senior WHO official, April 2013.

⁶⁶ The Who, 'Won't get fooled again', *Who's Next*.

⁶⁷ e.g. Farrar and Piot, 'The Ebola emergency', p. 1546; Clift, 'Ebola and WHO reform: who cares?'. Clift's arguments drew on a previous Chatham House report, *What's the World Health Organization for?* (London: Chatham House, 2014), http://www.chathamhouse.org/sites/files/chathamhouse/field/document/2014_0521_WHOHealthGovernanceClift.pdf, accessed 30 Sept. 2015.

⁶⁸ K. Lee and T. Pang (Pangetsu), 'WHO: retirement or reinvention?', *Public Health* 128: 2, Feb. 2014, p. 119. A useful survey of WHO reform in the period immediately prior to the West African Ebola outbreak is Andrew Cassels, Ilona Kickbusch, Michaela Told and Ioana Ghiga, *How should the WHO reform?* Global Health working paper no. 11 (Geneva: Graduate Institute of Geneva Global Health Programme, 2014), http://graduateinstitute.ch/files/live/sites/iheid/files/sites/globalhealth/ghp-new/publications/wp/wp_0011_v6.pdf, accessed 20 Sept. 2015. For a more historical perspective, see Tine Hanrieder, *International organization in time: fragmentation and reform* (Oxford: Oxford University Press, 2015).

⁶⁹ See Report of the Director-General, 'WHO reform', paper A65/5 for 65th World Health Assembly 25 April 2015, available at http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_5-en.pdf; accessed 5 October 2015;

African Ebola outbreak provided the space for the WHO to present a case for an additional area of reform. At the Special Session of the Executive Board in January 2015, called to discuss the Ebola outbreak, the WHO presented a series of proposals addressing operational issues, specifically its ability to respond to large-scale health emergencies.⁷⁰ Arguing that ‘global responses to recent emergencies and disasters demonstrate that the world is not adequately prepared to respond to the full range of emergencies with public health implications’,⁷¹ the WHO proposed what has been described as ‘the most sweeping changes ... since its founding in 1948’ to take on that role for itself and thereby shift the nature of its authority to a much greater emphasis on capacity.⁷² The Organization’s key recommendations were:

- that it be granted a clear and extended mandate as the global leader in responses to public health emergencies;
- that it be restructured to allow it to support emergency responses as well as exercising its traditional roles of normative and technical guidance;
- that it establish both a standing and surge capacity for emergency response;
- that an emergency fund be created for operational responses (identified elsewhere as c.US\$100 million), to which it would have prompt and guaranteed access in times of crisis. In addition, new funds should be provided to support day-to-day activities in preparing for large-scale emergencies, including an expansion of core staff.⁷³

These proposals were approved by the WHO’s Executive Board and then by member states at the World Health Assembly in May 2015.⁷⁴ They were also in general endorsed by the Stocking Report, which noted that although this role was already present in the WHO’s mandate, the Organization lacked both the capacity and the decision-making culture to exercise it, suggesting that the nature of its authority had not traditionally enabled this element of its mandate to be fulfilled.⁷⁵ These proposals were radical both in granting the WHO a major operational capacity, and in permitting it to be exercised with some independence from member states. In particular, establishing a contingency fund with pre-approved access appears to be a crucial step in granting the WHO a degree of operational independence. This suggests not only a shift to a greater emphasis on capacity-based authority, but a recognition that a global governor such as the WHO can

A. Cassels, I. Smith and G. L. Burci, ‘Reforming WHO: the art of the possible’, *Public Health* 128: 2, Feb. 2014, pp. 202–204. Cassels was at the time Director of Strategy in the office of the WHO Director-General.

⁷⁰ WHO, ‘Ensuring WHO’s capacity’.

⁷¹ WHO, ‘Ensuring WHO’s capacity’, p. 1.

⁷² Beaubien, ‘Critics say Ebola crisis was WHO’s big failure’.

⁷³ WHO, ‘Ensuring WHO’s capacity’. See also WHO, ‘2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on Ebola: outcome of drafting group’, paper A68/A/CONF./5 for 68th World Health Assembly, 23 May 2015; Chan and others, ‘Joint statement’, esp. paras 12–15.

⁷⁴ WHO, ‘Ebola: ending the current outbreak, strengthening global preparedness and ensuring WHO capacity to prepare for and respond to future large-scale outbreaks and emergencies with health consequences’, EBSS/3/CONF./1 REV.1, 25 Jan. 2015, http://apps.who.int/gb/ebwha/pdf_files/EBSS3/EBSS3_CONF1REV1-en.pdf; WHO, ‘World Health Assembly gives WHO green light to reform emergency and response programme’, news release, 23 May 2015, <http://www.who.int/mediacentre/news/releases/2015/wha-23-may-2015/en/> (both accessed 30 Sept. 2015).

⁷⁵ Stocking Report, p. 17.

exploit exogenous shocks and changes in the expectations of the governed, even when it is heavily criticized and its legitimacy is in doubt. Indeed, the very fact that its legitimacy was in doubt may have contributed to its ability to make this shift by exploiting a developing space.

If, as this article has suggested, multiple forms of authority coexist and create tensions between the WHO and its member states, then it is not so much the case that one form of authority has replaced others as that the balance has shifted and may, by inference, shift back again as these tensions develop. Two issue areas may act as litmus tests for the extent to which the basis of the WHO's authority has shifted to a greater priority on capacity. First, in an era of continued austerity, will the funding be made available on a continuing basis, not only to conduct emergency operations, but to create a new core capacity to prepare for such action? The WHO's budget has been cut since the 2008 financial crash to the point where it 'is supposed to work miracles on a budget equal to that of a University hospital in Geneva'.⁷⁶ Moreover, its control over this budget is limited: as noted above, over three-quarters of it is restricted to purposes and programmes specified by contributing states.⁷⁷ This clearly suggests that not only has delegated authority held sway over the WHO's budget, but that a shift to capacity-based authority requires additional funding. If such funding is not forthcoming, then either trust in the Organization will falter, or its authority will shift back to an emphasis upon the expert and delegated model.

Second, how will the IHRs be revised and will reforms to them be fully implemented? The IHRs, which provide the framework for the WHO to undertake global infectious disease surveillance and response, were last revised in 2005 following the 2003 SARS epidemic. Problems in implementing them suggested an emphasis on delegated authority. Three main problems are commonly identified with the current IHRs.⁷⁸ First, 70 per cent of the 194 signatories have failed to meet their agreed targets in terms of national surveillance and reporting capacity, despite the regulations coming into force in 2007. This 70 per cent includes many of the states most at risk from the emergence of new diseases or outbreaks of existing diseases. The reasons for non-compliance vary, but key among them is a lack of financial means to put the mandatory surveillance infrastructure in place. Until this deficit is addressed, the IHRs are severely weakened. Second, mechanisms for reporting compliance with the IHRs are unsatisfactory—little more than a self-assessment questionnaire with no independent verification. A more robust method of ensuring compliance is therefore required. And third, signatories

⁷⁶ Kickbusch, 'Global health security'. Details of the WHO's budget can be found at its programme budget portal, <https://extranet.who.int/programmebudget/>, accessed 30 Sept. 2015.

⁷⁷ Stocking Report, p. 16.

⁷⁸ See e.g. Youde, *Global health governance*, pp. 127–9; Ann Marie Kimball and David Heymann, 'Ebola, International Health Regulations, and global safety', *The Lancet* 384: 9959, Dec. 2014, p. 2023; Editorial, 'Ebola: what lesson for the International Health Regulations?', *The Lancet* 384: 9951, Oct. 2014, p. 1321; Stocking Report, pp. 10–12; Rebecca Katz and Scott F. Dowell, 'Revising the International Health Regulations: call for a 2017 review conference', *Lancet Global Health*, May 2015, <http://www.sciencedirect.com/science/article/pii/S2214109X1500025X>, accessed 5 Oct. 2015; WHO, 'IHR and Ebola', paper EBSS/3/INF./4 for the Special Session of the Executive Board on Ebola, 9 Jan. 2015.

breach the regulations when it suits their national interests—for example, in 2014 by imposing travel restrictions to and from West Africa without WHO approval, or failing to inform the WHO promptly of Ebola cases—without meaningful penalty and frequently without censure. Some signatories remain resistant to the idea that the WHO should have a right to undertake surveillance of events within a state, while others prioritize their own national interests, fearful of economic or trade consequences if they report disease outbreaks. Reporting on the WHO's handling of the Ebola crisis, Margaret Chan complained that for the WHO to act effectively, 'the International Health Regulations need more teeth'.⁷⁹ Whether or not the IHRs acquire 'more teeth' would therefore appear to offer a litmus test of a shift in the balance of authority from delegated to capacity-based.

Conclusion

This article has argued that the West African Ebola crisis saw a shift in the nature of the WHO's authority from one which was largely expert and delegated to one based more heavily on capacity. It suggests that the WHO's actions during 2014 reflected a continuing understanding that its authority was expert and delegated, but that criticism both of the Organization and of the more general response opened up a space whereby the WHO could shift the balance of its authority to one based more heavily on capacity. In making this argument the article moves beyond initial analyses, which focused upon the failings of particular individuals or structures, to one that examines the changing nature of global health governance and in particular the relationship between the key global health 'governor' and the global health community. It does not pretend that the WHO is a unitary actor, or that the governed—including the WHO's member states—have a homogeneous or coherent view of its authority. Rather, the article has argued that multiple forms of authority coexist and what the West African Ebola outbreak demonstrated was a shift in the balance between these, one which remains contested and in which tensions are therefore likely to persist. The article has suggested two possible 'litmus tests' to identify the extent of this shift, based respectively on budget and on the reform of the IHRs. However, if this shift has occurred and is embedded in global health governance, then it also implies changed and heightened expectations of the WHO. If the Organization fails to deliver on these expectations, then, according to the analytical framework used, trust in the WHO and its legitimacy may be compromised.

There is another issue that has received little attention during the West African Ebola crisis and its aftermath. We will probably never know how many died of Ebola during the 2014–15 outbreak, but the number is almost certainly well over 12,000. This was a tragedy. In the previous year, the WHO estimated that around 760,000 children died of diarrhoeal disease, an easily preventable and treatable condition. A similar number almost certainly died of the same disease in 2014

⁷⁹ Chan, 'Report by the Director-General to the Special Session of the Executive Board on Ebola', p. 4.

and will die from it in 2015.⁸⁰ This is only one of a series of chronic and endemic diseases which continue to lead to much larger numbers of preventable deaths every year than those seen during the West African Ebola crisis. The danger is that in moving to a capacity-based authority targeted at major outbreaks or other emergency events, chronic disease and endemic conditions will be accorded lower priority.

⁸⁰ WHO, 'Diarrhoeal disease', fact sheet no. 330, April 2013 edn, <http://www.who.int/mediacentre/factsheets/fs330/en/>, accessed 30 Sept. 2015.