

What's the World Health Organization For?

Final Report from the Centre on Global Health Security Working Group
on Health Governance

Executive Summary and Recommendations

The Chatham House Working Group on Health Governance, in the institute's Centre on Global Health Security, was formed to consider, in the first instance, the role of the World Health Organization (WHO) in the international system that supports global health.

The members of the group met three times. There was broad consensus on the role that the WHO should ideally play, but views differed concerning what kind of restructuring might or might not be desirable or possible to help it play that role. This report is intended as a complementary contribution to the ongoing internal debate on the reform of the WHO, but offers a perspective based on the deliberations of a group that was able to step outside the constraints inevitable in the formal processes of an intergovernmental body, and to consider issues that are important but politically difficult to address. While this report is based on the deliberations of the group, any views expressed are those of the author, not the responsibility of the group, or indeed of Chatham House.

A changed world

Much has changed in the world since the WHO was founded in 1948 – politically and economically, as well as in global health. The Iron Curtain has come and gone. The world's economy and technical capacity have expanded beyond what anyone then could have imagined. The Western economies have experienced unprecedented growth, but their economic and political dominance is now being challenged by the rapidly growing economies of countries emerging from developing status. As a result, there is accompanying uncertainty about how global institutions, which reflect the post-war status quo, can adapt to a world so different.

At the same time, the health status of most people in most countries has improved as a result of better resourcing of health services, technology development and improvement in living conditions arising from economic growth and the accompanying greater capacity to invest in social determinants of health such as education, and water and sanitation. However, although progress has been made, it has not been sufficient for the most part to meet the targets set in the Millennium Development Goals – for example reducing the under-5 mortality rate by two-thirds and the maternal mortality ratio by three-quarters between 1990 and 2015.

Beyond this, the global health community – including the WHO – has struggled to address threats to global health and security, ranging from climate change, population growth and environmental degradation to the spread of communicable and non-communicable disease, migration, and rising inequalities associated with globalization and the failure sufficiently to improve many of the social

determinants of health. These threats often emerge initially in other sectors and involve issues with which health professionals are unfamiliar and which they are powerless to influence.

There has been a proliferation of new global health institutions, driven in particular by the rapid increase in development assistance for health that occurred in the first decade of the century. Notable among these are the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, UNICEF and public–private partnerships for product development. These new institutions have also pioneered new forms of governance by including alongside governments representatives of civil society, the private sector and foundations.

Meanwhile, the WHO has launched a comprehensive internal reform programme, driven by a potential funding crisis related to stagnation in funding after a long period of growth, as well as excessive reliance on uncertain and inflexible funding from voluntary contributions and grants which made realistic planning and effective management difficult.

But within this reform programme, there are key issues that are not really discussed because – although of great importance – they are politically difficult to deal with. External commentators, including some who have previously worked for the WHO, complain that it is too politicized, too bureaucratic, too dominated by medical staff seeking medical solutions to what are often social and economic problems, too timid in approaching controversial issues, too overstretched and too slow to adapt to change.

In particular, numerous external reports going back more than 20 years have identified key problems arising from the WHO's unique configuration of six regional offices, with directors elected by member states, and its extensive network of about 150 country offices. While these reports have recommended sometimes radical reforms, there has been hardly any response from the WHO and its member states. This is because the governance structures in the WHO mean that there is a very strong interest in maintaining the status quo. It is also the case that those relatively few member states that provide the majority of funding for the WHO have hitherto never felt it sufficiently important to devote the time and effort required to bring about reforms that would inevitably be contentious and disruptive in the short term.

The working group challenged the mythology of a 'golden age' in which the WHO actually performed the function of being the directing and coordinating body in international health. According to this mythology, the history of the WHO has been one of a downward slide during which it has gradually lost its erstwhile authority, which has passed to

the multitude of other global health agencies. In this view, the very existence of organizations such as GAVI or the Global Fund is a reminder of the WHO's failure, and of the extent to which the international community (particularly the donor community) prefers to bypass a WHO that is perceived as clodhopping and ineffective.

However, the working group was very clear that the WHO had never been intended as a body that should undertake each and every function which might contribute to global health. It was not intended to be a funding agency, or indeed a research organization. Moreover, the new and more complex institutional structure in global health that accompanied the increase in funding was also to be welcomed. While there were drawbacks to this proliferation of funding bodies, the new infrastructure also offered more choice for countries seeking funding or technical assistance and innovation in governance structures, as well as in funding methods. An element of competition to traditional providers such as the World Bank and the WHO was, on balance, considered a good thing.

The current programme of reform is an opportunity for the WHO and its member states to think more fundamentally about the organization's role in this changed global environment. The proliferation of global health institutions, perceived by some as a threat, is in fact an opportunity for the WHO to define better a much-needed coordinating role in this far more complex institutional environment. The WHO also has an important role to play in influencing other actors within and outside the health sector – both governmental and non-governmental – to behave in ways that seek to reconcile the political, economic and commercial objectives of these actors with public health goals.

What should the WHO do?

Recommendation 1: The WHO's core functions should explicitly provide for its work in promoting and maintaining global health security.

The WHO has a dual role as a provider of global public goods that benefit all nations – rich and poor – and that need to be provided collectively, and as a provider of supportive services to its member states. The WHO's current definition of its core functions provides a sound basis for the future, but given their level of generality these may not capture explicitly certain functions that are important, or may implicitly include functions that are less important. For example, there is no specific mention of a role in relation to ensuring global health security such as the WHO's role in global health security, which involves, for instance, action around international public health emergencies and pandemics.

Recommendation 2: The WHO should provide strategic technical assistance to countries in support of its mission as a provider of global public goods. It should not seek to undertake activities that could or should be done better by others – by the host government, with or without support from other agencies.

The nature of the WHO's leadership role is largely undefined in the current core functions. This is with regard to both the health sector and relationships with governmental and non-governmental actors, and regarding decisions and actions outside the health sector that have an impact on health. Nor do the current core functions adequately describe what sort of technical assistance the WHO should be offering to member countries. Technical assistance offered to members should be related to the WHO's core remit of providing normative, standard-setting and other services – broadly the provision of global public goods for health.

Recommendation 3: The WHO should undertake a review of the skills mix and expertise of its staff to ensure that these fit with its core functions and leadership priorities.

The WHO's professional staff are predominantly either health professionals or administrators. Addressing the social, economic and environmental determinants of health and non-communicable disease, and advising countries on the attainment of universal health coverage and financial protection would seem to demand a very different distribution of skills from that which exists currently. Because the WHO has a rapid turnover of staff, significant changes could be made in a relatively short period of time.

Governance of the WHO: the global role

Recommendation 4: The WHO should provide an internal separation between its technical departments and those dealing with governance and management by creating two posts of deputy director-general, with one to be responsible for each.

The WHO is both a technical agency and a policy-making body. The excessive intrusion of political considerations in its technical work can damage its authority and credibility as a standard-bearer for health. Determined leadership is necessary to overcome political and economic interests that threaten public health goals. But politics cannot realistically be wholly separated from the WHO's technical work. However, this is one proposal that may reduce the harmful effects of politicization.

Recommendation 5: The WHO should allow the director-general a single, seven-year term, without the possibility of re-election.

Having previously had no limit on the number of five-year terms that the director-general and regional directors could serve, in the 1990s the WHO introduced a limit of two terms (i.e. renewable once) for these posts. This was partly in response to concerns about the harmful impact of electoral considerations on the governance of the organization. This could be carried further and is a second proposal that may reduce the harmful effects of politicization.

Recommendation 6: The WHO should explore new avenues for collaboration with non-governmental actors that have a concrete and specific purpose.

The WHO's plans for greater involvement of non-governmental stakeholders in its processes seem to have reached a dead end. This is for a number of reasons, including concerns of some member states about diluting the sovereignty of governments in the WHO, the difficulty of managing conflicts of interest, and lack of agreement and trust between stakeholders. It is also because the proposals to date for greater involvement have no concrete goals beyond the desire to involve stakeholders, as important players in the health sector, in the WHO's deliberative processes. It was observed that collaboration with these stakeholders has been most successful where it is built around tackling more specific tasks or problems where mutual confidence and trust can be built through constructive endeavour.

Governance of the WHO: regions and countries

Recommendation 7: The WHO should consider two alternative proposals for restructuring its regional offices:

- *Unitary:* The WHO should be like other UN organizations, where the need for regional (and country) offices is determined by what makes sense in terms of achieving organizational objectives. Elected regional directors should be phased out in order to allow structural changes to take place.
- *Decentralized:* The WHO should apply the Pan American Health Organization (PAHO) model to the other regional offices; and the assessed contribution should be provided to regional offices directly by regional member states, rather than redistributed by headquarters in Geneva. This would involve accepting a decentralized model in the WHO – or even the complete autonomy of regional offices, or their absorption by other regional organizations.

The WHO's unique regional structure is deeply embedded in history and in its political dynamics. While there is a widespread recognition that its decentralized structure entails significant costs and inefficiencies, which are

manifested in different ways, there is also a pervasive resignation about the possibility of effecting any significant change in the current model. Most members of the working group supported changes in principle. They discussed, but did not agree on, these two alternative proposals.

Recommendation 8: A comprehensive and independent review – of the kind that has been suggested since 1997 – is overdue to examine how the staffing of country offices should be matched to the needs of host countries, in particular with a view to translating WHO recommendations into practice.

The essential purpose and staffing of country offices, the activities and skill sets required, and how they should be distributed in the light of varying and evolving country needs have long been debated within the WHO. But, like the regional offices, and for many of the same reasons, there have always been grounds for not pursuing these issues with any vigour. The reform programme is an opportunity to do this.

Financing of the WHO

Recommendation 9: The WHO and its member states should examine how its effectiveness could be enhanced by reviewing – in conjunction with the other recommendations in this report – how the value added by its regional and country offices could be increased, and its administrative and management costs reduced.

The WHO has been reliant on voluntary contributions even from its early days, but in the last five years the share of these in funding has exceeded 75 per cent. The WHO's problem is not inadequate income. Rather, it is the imbalance between what member states, through the governing bodies, and voluntary contributors (including member states), through separate agreements, ask the WHO to do. Any programme of reform needs to undertake a serious review of the major cost centres – in particular administration and management, the cost of which is directly related to the WHO's extensive network of country and regional offices, and to the governance mechanisms associated with its unique regional structure. This needs to be done in the context of considering what functions the WHO should be undertaking, and what can be done at least as well by others. This report argues that a comprehensive reform programme should concentrate on these structural issues concerning governance and cost-effectiveness, and that a WHO focused on its core tasks could do more good with less money. The WHO's member states have so far been unwilling to tackle these structural issues in the reform programme.

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