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CENTRE ON GLOBAL HEALTH SECURITY WORKING GROUP PAPERS

# The Role of the World Health Organization in the International System

Charles Clift

February 2013

WORKING GROUP ON GOVERNANCE | PAPER 1

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## ABOUT THE AUTHOR

**Charles Clift** is a Senior Research Consultant at the Centre on Global Health Security, Chatham House. Previously he was an economist at the UK Department for International Development. In addition to his work for Chatham House, Dr Clift has been a consultant to the World Health Organization, UNITAID, the World Intellectual Property Organization and the Access to Medicine Foundation. From 2004 to 2006 he was a staff member of WHO.

## ACKNOWLEDGMENTS

An earlier version of this paper was written as background for the first meeting of the Chatham House Working Group on 'WHO and the International System' in October 2012. It was intended to provide a picture of the World Health Organization's history and constitution, and to outline the previous efforts to reform the way the organization operates, beginning about 20 years ago.

In undertaking this work I was helped in various ways by many people. Members of the Chatham House Global Health Working Groups contributed the answers to a number of questions I put to them. I also conducted specific interviews with several current and past WHO staff. Thus I owe a debt to Awo Ablo, George Alleyne, Maria Azevedo, Fran Baum, Andrew Cassels, Sally Davies, David Evans, David Fidler, Julio Frenk, Larry Gostin, Jane Halton, David Heymann, Hans Hogerzeil, David Hohman, Jon Lidén, Peilong Liu, David McCoy, Zafar Mirza, Sigrun Møgedal, David Nabarro, Gorik Ooms, Devi Sridhar, Keizo Takemi, Suwit Wibulpolprasert, Simon Wright and Derek Yach. In revising this paper I also benefited from the lively discussions in the Working Group in October.

I was also very much helped in orienting myself by Kelley Lee's great little book on the World Health Organization.

Any views expressed are my responsibility alone.

C.C.

*The client is a 50-year-old multinational concern that was once the global leader in its sector. Recently, however, it has lost its direction. Though the market it serves is still growing rapidly, it is also changing in ways that threaten the relevance of the client's traditional strengths. The client has also suffered over the past decade from weak leadership, and rival concerns have been competing for its territory. Nevertheless its brand is still strong, and while it may never regain its previous monopoly, it can probably be repositioned as primus inter pares in the sector. Its rivals need its expertise and it should be able to carve out a comfortable niche if it is prepared to co-operate with them. This will require a significant change of attitude on the part of some employees and that, together with the antiquated management structure and an ill-advised growth in the number of senior managers over the past few years, may indicate the need for some corporate downsizing.*

*The Economist*, 7 May 1998[1]

*WHO was the epitome of a sclerotic UN bureaucracy in 1998. Those of us working in public health at the time used to say WHO is where good ideas go to die.*

Nils Daulaire[2]

1 'Repositioning WHO', *The Economist*, 7 May 1998, http://www.economist.com/node/127783.

2 Quoted in McCarthy, M., 'What's Going On at the World Health Organization', *The Lancet,* 360 (2002): 1108–11, http://www.lancet.com/journals/lancet/article/PIIS0140-6736(02)11243-8/fulltext.

## EXECUTIVE SUMMARY

The World Health Organization (WHO) was founded in 1948 with an ambitious objective – 'the attainment by all peoples of the highest possible level of health'. Its constitution defined 22 wide-ranging functions, of which the first was 'to act as the directing and co-ordinating authority on international health work'.

Since 1948 many things have changed in the world of global health, in particular the large number of new initiatives and institutions created that challenge WHO's role as a directing and coordinating authority. Examples include the entry of the World Bank into health-sector lending on a large scale in the 1980s; the creation of new organizations such as UNAIDS, the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation), the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) and UNITAID, developed to tackle specific disease problems; and new public-private partnerships for product development such as the Medicines for Malaria Venture or Drugs for Neglected Diseases initiative.

Meanwhile WHO's secure funding from governments has stagnated and it has become reliant on voluntary contributions from governments and other actors usually earmarked for particular activities favoured by the donor. In recent years, the Bill & Melinda Gates Foundation has become one of the biggest voluntary contributors to WHO. As a result of the acute funding pressures, Director-General Margaret Chan initiated in 2010 the launch of what became a fresh effort to reform how the organization functions.

There are many questions about how WHO should locate itself in relation to this new and crowded institutional environment. How should it interpret or reinterpret its constitutional role? As an intergovernmental organization, how can it effectively engage with these new actors, including NGOs, charitable foundations and the private sector? Is WHO principally a normative, standard-setting institution, a knowledge broker and provider of information and evidence, and advocate for global health? Or is it principally a provider of technical assistance to governments in various health-related spheres? In addition, should it be an implementer of projects usually funded through earmarked voluntary contributions from funders? What is the best balance between these functions? Do they conflict? What does this imply for the organization of WHO with its unique structure of semi-autonomous regional offices?

This paper reviews the history of previous efforts at reform in WHO and the key issues that arise in defining WHO's role in the international global health system as it has now evolved and what this might mean for its own governance, organization, management and financing.

### Pre-history

Formal international cooperation in health dates from the mid-nineteenth century with the calling of International Sanitary Conferences to reconcile the need for agreeing quarantine procedures to prevent the spread of diseases, particularly cholera, without unduly disrupting rapidly growing international trade. In 1892 the first treaty was agreed on cholera; this was followed in 1903 by a consolidated treaty covering cholera, plague and yellow fever. These agreements were the forerunners of today's International Health Regulations administered by WHO. In 1902 a meeting of American countries established the International Sanitary Bureau, which ultimately became the Pan-American Health Organization (PAHO). In 1907 the Office International d'Hygiène Publique (OIHP) was established with a mandate that gradually expanded to include a broader range of activities beyond quarantine measures to combat infectious diseases. After the First World War the League of Nations Health Organization was established alongside OIHP with a mandate that expanded well beyond infectious diseases to include many of the issues now considered germane to public health.

## The World Health Organization

The constitution of WHO is notable for the scope and breadth of the agenda it lays out for the organization. Health is described as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' and the enjoyment of the highest attainable standard of health as a fundamental human right. Governments have a responsibility to provide 'adequate health and social measures'. The constitution sets out 22 functions for WHO, which cover almost every conceivable activity linked to the promotion of health.

A unique feature of WHO among UN agencies is the establishment of regional organizations – a result principally of the unwillingness of PAHO member states to see it lose its identity through merger with WHO. For similar reasons each of the six WHO regions elects its regional director, although this is not specified in the constitution. The resulting autonomous nature of the regional offices has always sat uneasily with the stipulation in the constitution that they be an 'integral part of the Organization'.

In its first two decades WHO was probably best known for the application of technical and medical expertise to infectious disease control – such as its eradication programmes for malaria and smallpox. The former ended in failure whereas the latter was an outstanding success. Even at that time these programmes relied heavily on voluntary contributions, in spite of rapidly rising incomes from assessed contributions from member states as newly independent nations joined.

In the 1970s WHO began to reflect fundamental changes in the international economic and political environment – the 1973 oil shock, the growing voice of developing countries as epitomized by the demands for a New International Economic Order and new approaches to development such as 'basic needs'. In WHO this culminated in demands for the organization to provide more technical assistance to developing countries and to a new orientation for WHO – Health for All – encapsulated in the declaration of a landmark conference at Alma-Ata in 1978. This was about the promotion of primary health care as a means of attaining the goal of Health for All but was not seen as a technical change in the means by which health care should be delivered to greater effect but as part of a more fundamental economic and social restructuring in tune with the supposed aspirations of developing countries and a recognition that health depended on much more than the delivery of health services. This more activist approach from WHO, which owed much to the personality of Director-General Halfdan Mahler, was also reflected in a willingness to confront powerful interests. The 1977 Model List of Essential Medicines, fiercely opposed by the pharmaceutical industry, was one result, as was the 1981 International Code on the Marketing of Breast-milk Substitutes.

At about the same time, the World Bank was developing two policies that would profoundly change the landscape in which it operated. First, on the basis of its Health Sector Policy Paper of 1980, it began lending directly to the health sector for the first time, and within a short time it was lending on a scale that exceeded WHO's budget. Secondly, it launched structural adjustment lending that led to continuing controversy about its impact on budgetary allocations for social sectors, including health, and the impact of related policies it promoted for cost recovery through user fees. This was also a contest of ideas – between economists and neo-liberal thinkers in the Bretton Woods institutions and health professionals in WHO espousing Health for All.

## WHO reform (1989–98)

General concerns about the operations of the UN system, which had been evident long before in the main contributor nations, stimulated a series of analyses in the early 1990s, including of specialized UN agencies such as WHO. These highlighted several issues that remain relevant today, including:

- The increasing role of special programmes financed by voluntary contributions, accountable to donors rather than the World Health Assembly;
- An increased emphasis on technical assistance and project execution at the expense of WHO's analytical and normative functions;

- Weak performance at country level and a deficiency in skills related to health policy, economics and management;
- Tension between WHO's use of 'vertical' programmes and its advocacy of integrated primary health care;
- The autonomous role of the regional offices and their politicization; and
- A series of deficiencies in management including of finance, recruitment, coordination, budgetary planning and general bureaucratic inefficiencies.

A report of the UN Joint Inspection Unit in 1993 identified in WHO's three-layer organizational structure (headquarters, regions, countries) 'serious and complex problems of a constitutional, political, managerial and programmatic nature'. It specifically recommended that the election of regional directors (RDs) by Regional Committees should be ended with selection and nomination of RDs being undertaken by the director-general for confirmation by the Executive Board.

In the same year a working group on 'WHO Response to Global Change' established by the Executive Board addressed many of the same issues. In the succeeding years, under Director-General Hiroshi Nakajima, the issues raised by the report were much discussed in the Executive Board but little significant change occurred.

## The Brundtland years (1998–2003)

In the mid-1990s the problems at WHO were highlighted in a number of critical articles in specialist journals and in key meetings, facilitated by the Rockefeller Foundation, such as that at Pocantico in 1996. Dr Gro Harlem Brundtland, formerly Norway's prime minister, came to office in 1998 with a well-developed vision for WHO. She identified two key tasks for the organization. One was its 'work on the ground' to combat disease, to advise on best practices, to set norms and standards and to support research and development. The other was to bring 'health to the core of the development agenda' as the key to poverty reduction and development.

She also saw the necessity of demonstrating that 'WHO is one'. Not two (one financed by the regular budget and one by extrabudgetary funds); not seven – meaning Geneva and the six regional offices; and not 50 – meaning the number of individual programmes. She wanted a stronger partnership with member states and with other stakeholders in the UN, the development banks, NGOs and the private sector. In addition WHO's work should be evidence-based with priorities determined by the burden of disease and the cost-effectiveness of interventions. Evidence was also needed to demonstrate to prime ministers and finance ministers that investment in health was a key element for attaining poverty reduction and economic growth. And she immediately launched two flagship projects – Roll Back Malaria and the Tobacco Free Initiative.

Brundtland also initiated internal restructuring to streamline management, build collective responsibility, reform departments into clusters, and include regional directors in policy-making. Subsequently she sought to develop a corporate strategy to provide a new vision and strategic direction to WHO's work.

Her main achievement was to rebuild WHO's international reputation and to make health an integral part of the wider development agenda. The Commission on Macroeconomics and Health successfully made the case for investing in health and Brundtland's influence was integral to the incorporation of health in the Millennium Development Goals, the increasing focus of the G8 summits on achieving health goals and the rapid rise in development assistance for health from 2000 onwards. Similarly, she was instrumental in the creation of new partnerships based in WHO (such as Roll Back Malaria) and external public-private partnerships such as GAVI and the Global Fund. A crowning achievement was the Framework Convention on Tobacco Control agreed in 2003.

On the other hand, for a number of reasons Brundtland's attempts to reform the way WHO worked internally were less successful. Some of the reforms in Geneva have been sustained,

such as clusters, but the vision of 'one WHO' through closer alignment with the regional offices was not achieved. She was successful in attracting extrabudgetary funding but not in increasing the regular budget and WHO's finances are in an even more critical state today. Reaching out to the private sector proved controversial, as have the operations of WHO-based partnerships. The controversy over the methodology of the 2000 *World Health Report* raised questions concerning the credibility of evidence-based policies, and work on the global burden of disease, a cornerstone of Brundtland's innovations, has moved out of WHO.

## Current reform (2010 onwards)

The current internal reform process began as an informal consultation convened in January 2010 by Director-General Margaret Chan to discuss WHO's financing problems – how to better align the priorities agreed by its governing bodies with the available finance and how to ensure greater predictability and stability of financing to promote more realistic planning and effective management.

As a result of further discussions, including a number of special member state meetings, a consolidated reform programme was presented to the 2012 World Health Assembly.

The reform proposals were grouped under three areas:

- Programmes and priority setting;
- Governance; and
- Management.

Under programmes and priority setting, WHO's operations were divided into six broad categories, and five criteria were proposed for priority setting to be incorporated in WHO's Twelfth General Programme of Work and the budget for 2014–15. Six core functions of WHO were also defined.

Under governance, key components included:

- Improved scheduling of governing body meetings;
- Regional committees to routinely report to the Executive Board;
- Procedures for the nomination of regional directors to be harmonized with those of the director-general;
- Broadening the mandate of the Programme Budget and Administration Committee,
- Improving strategic decision-making in the governing bodies, e.g. limiting the number of draft resolutions; and
- Developing new arrangements for working with the private sector and NGOs and a review of WHO-hosted partnerships.

Finally, a long list of management reforms was proposed including:

- More effective technical and policy support to member states, including defining the roles and responsibilities of the three levels of WHO;
- Staffing that is matched to needs at all levels of the organization;
- An approach to orient financing towards agreed priorities;
- An organization that is accountable and effectively manages risk;
- An established culture of evaluation; and
- An organization that effectively communicates its contribution to and achievements in global health.

## Conclusion

The discussion of WHO's evolution and efforts to reform it covers a very wide range of topics concerning governance, structure, policies, priorities, financing and management. The intention was to provide background and historical perspective relevant to current discussions of WHO reform.

As described above, the current reform process within WHO is in many ways admirably comprehensive but for understandable reasons there are various potential avenues for reform that are not fully addressed. The current process does not ask fundamental questions about WHO's place in the international system for health as it has now evolved, nor whether WHO's governance, management and financing structures need more fundamental change than is currently envisaged. It is therefore unclear whether the latest reform efforts will be sufficient to enable the organization to fulfil its potential.

## 1. INTRODUCTION

At its foundation in 1948, the World Health Organization's constitution set its objective as 'the attainment by all peoples of the highest possible level of health'. Among the 22 functions defined in the constitution were to act as 'the directing and co-ordinating authority on international health work', by assisting governments in various ways to improve health services; setting standards in a number of health-related areas; proposing 'conventions, agreements and regulations, and […] recommendations with respect to international health matters'; and stimulating and advancing work to eradicate epidemic, endemic and other diseases. The agenda was very broad.

Beginning with the entry of the World Bank into health-sector lending on a large scale in the 1980s, and accelerating in the last decade or so with the creation of a myriad of new global health initiatives, WHO's position as a directing and coordinating authority has been challenged. New initiatives have been created, funded and operated outside WHO, or hosted within WHO as partnerships with earmarked funding and independent governance structures. WHO's core funding from assessed contributions from member governments has stagnated, and it has become dependent on largely earmarked contributions from governments and, latterly, foundations, which reflect their own particular perception of global health needs, raising questions about the relationship with priorities set by all member states through WHO's governance structures.

**Beginning with the entry of the World Bank into health-sector lending on a large scale in the 1980s, and accelerating in the last decade or so with the creation of a myriad of new global health initiatives, WHO's position as a directing and coordinating authority has been challenged**

The political, economic, governance and cultural landscape of global health has changed. Some new initiatives, such as UNAIDS (the Joint United Nations Programme on HIV/AIDS), the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation), the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund), and UNITAID were developed to tackle specific disease problems. Others include public-private partnerships for product development such as the Medicines for Malaria Venture or the Drugs for Neglected Diseases initiative. New global initiatives based in WHO, such as the Stop TB Partnership or Roll Back Malaria, have also developed and include non-governmental partners, but with a sometimes uneasy relationship with core WHO programmes. Characteristically the governance of these new initiatives, unlike that of WHO, extends beyond governments to include new actors in the private, NGO and charitable sectors. New sources of funding, notably the Bill & Melinda Gates Foundation, have altered the balance between national governments and other actors in influencing policies and resource allocation, including within WHO.

This raises the question of how WHO locates itself in relation to the new national and international actors in global health, both funding and implementing organizations. What is the proper role of WHO in relation to these other actors? What should be the practical expression of WHO's mandate as a 'directing and co-ordinating authority' in this far more complex and fragmented health arena? As an intergovernmental organization how can WHO engage effectively not just with funders and implementers but with private-sector actors, NGOs and civil society generally, all of which are a part of 'international health work'?

**Figure 1: The evolving institutional landscape of global health**

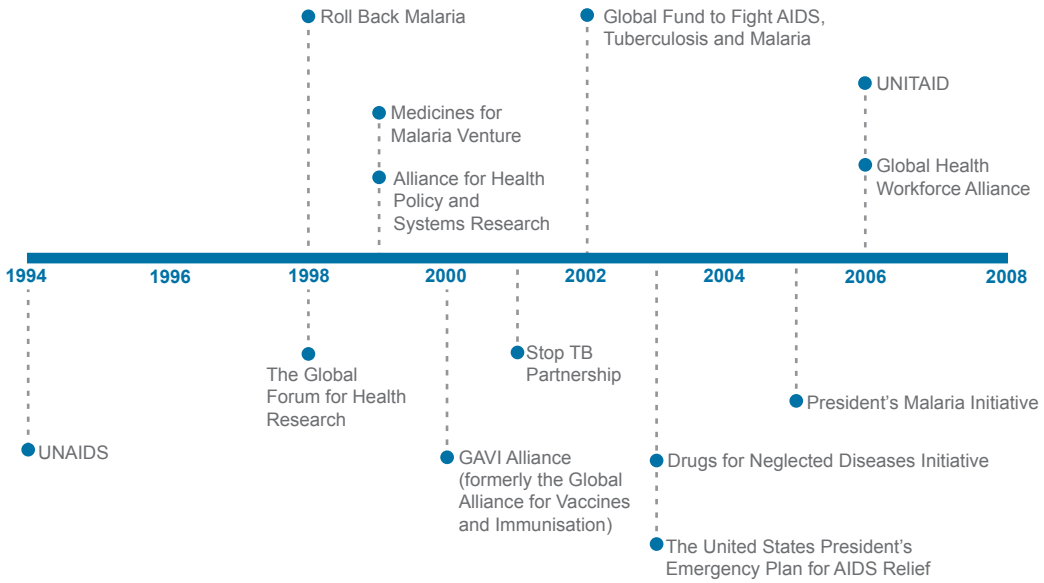
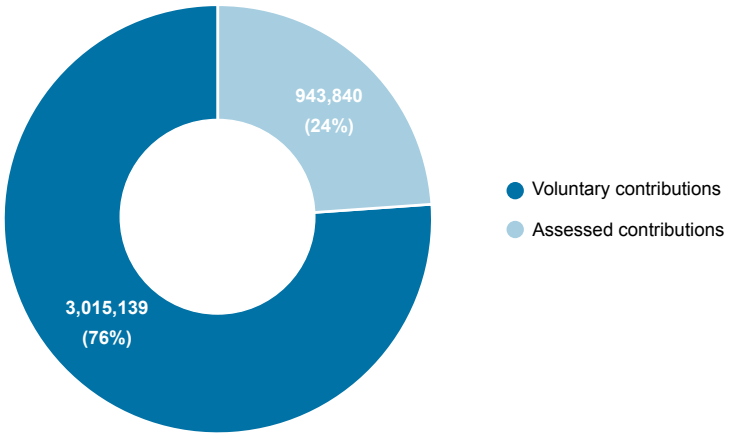



**Figure 2: Proportion of assessed and voluntary contributions**




Source: http://www.who.int/about/resources_planning/programme_budget_2012_13/en/index.html.

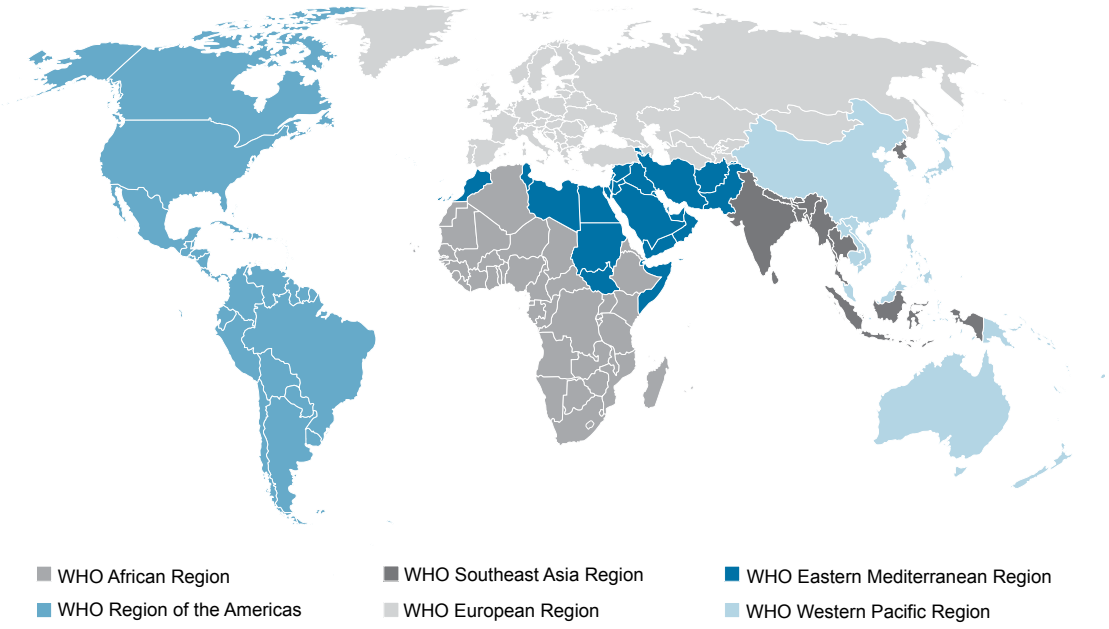
Exacerbating this strategic issue is the fact that assessed contributions from member states constitute only about 20–25% of WHO's funding so that 75–80% of its activities depend on voluntary contributions, usually earmarked for particular purposes. Member states, academics and civil society groups have noted that WHO's authority, credibility, capabilities and access to resources have been potentially weakened by the emergence not only of new players and processes, but also of new health problems, principles, policies and political dynamics. In 2010 Director-General Margaret Chan initiated the launch of a fresh effort to reform how the organization functions. The urgency of many global health problems – both old and emerging, such as increasing inequalities, the growing impact of non-communicable diseases and the threat of pandemics – suggests the need for a WHO that can more effectively navigate the new challenges of global health.

Another aspect of WHO's dilemmas is commonly regarded as the tension between two visions of the organization, both of which are legitimated by its constitution. Is it principally a normative standard-setting institution, a knowledge broker and provider of information and evidence, and an advocate for global health? Or is it principally a provider of technical assistance to governments in various health-related spheres? In addition, should it be an implementer of projects usually funded through earmarked voluntary contributions from funders? What is the best balance between these functions? Is there in reality any conflict between them?

**The urgency of many global health problems – both old and emerging, such as increasing inequalities, the growing impact of non-communicable diseases and the threat of pandemics – suggests the need for a WHO that can more effectively navigate the new challenges of global health**

Asking these questions also raises the issue of the extent to which WHO's structure, with six regional offices with their own governance arrangements, and the extensive country office network, is aligned with whatever functions are regarded as core to the organization. If the first vision predominates, it raises questions about the rationale for an extensive regional and country presence. If the second predominates, it may raise similar questions about the functions of the headquarters in Geneva.

**Figure 3: WHO regions**




Source: http://www.who.int/about/regions/en/index.html.

With this in mind, this paper seeks to review the history of previous efforts at reform in WHO, the key issues that arise in defining its role in the international system and what this might mean for its governance, organization, management and financing.

# 2. THE HISTORY OF GLOBAL HEALTH INSTITUTIONS

## International Sanitary Conferences

The origin of international cooperation in health is generally considered to be the first International Sanitary Conference, convened by the French government in 1851 and attended by 11 European countries and Turkey. The public health context for the calling of this conference was the concern about the impact of cholera, and to a much lesser extent plague and yellow fever, on the countries of Europe. The background was the revolutionary economic and social changes wrought by the industrial revolution, in particular in relation to the massive expansion of movements of goods and people on the railways and as a result of steam-driven maritime transport. Similarly, the rapid growth of cities with large populations of poor labourers had provided the conditions in the first half of the nineteenth century for periodic epidemics, notably of cholera, with devastating consequences. The convenor of the meeting was the French minister of agriculture and trade, and the object was to reach agreement on minimum maritime quarantine requirements, thereby rendering 'important services to the trade and shipping of the Mediterranean, while at the same time safeguarding the public health'.[3]

In the context of this study, the conference was noteworthy in its combination of concerns about safeguarding public health, interlinked with other issues related to trade and diplomacy. Countries were each represented by a physician and a diplomat who could both vote, not necessarily the same way! The maritime nations, notably Britain, wanted to minimize any health regulations that would interfere with the free flow of trade and commerce. As regards public health, while it was generally accepted that plague and yellow fever were communicable diseases, there was no agreement that cholera, the most serious concern, was contagious. Epidemics were held by many to occur as a result of predisposing local environmental conditions, not by transmission from the sick to the healthy. A committee assigned to investigate the question narrowly voted in favour of the former view, concluding that quarantine measures were 'impossible, illusory, even dangerous in certain cases'. Austria, Britain and France were the principal advocates of the 'anti-contagionist' view. As described by Norman Howard-Jones, the Spanish medical delegate, while admitting that cholera was not 'constantly, essentially, and universally contagious', recognized that quarantine caused loss of time, and that, as the English said, 'time is money'. But he pointed out that 'public health is gold' and therefore supported inclusion of cholera in quarantine regulations.[4]

The British delegate was scathing about the 'contagionists', saying that 'they persisted in practices that are outmoded, useless, ruinous to commerce, and harmful to public health'.[5]

It is interesting to speculate whether the British medical and diplomatic establishment was in any way influenced in its views by the political and economic imperative to avoid impediments to commerce, and by the fact that (colonial) India was regarded as the sink from which cholera emanated. After a later conference the editor of a German medical journal noted the 'surprising concordance between England's commercial interests and its scientific convictions'.[6] In any case, the interplay between health considerations and political and economic interests is pertinent in the context of today's health debates.

There followed a series of International Sanitary Conferences (see Table 1), some of which drafted conventions; but for various reasons, including continuing scientific disagreement, none of them got to the ratification stage.

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3 World Health Organization, *The First Ten Years of the World Health Organization* (Geneva: WHO, 1958), http://whqlibdoc.who.int/publications/a38153.pdf.

4 Howard-Jones, N., *The Scientific Background of the International Sanitary Conferences 1851–1938*, (Geneva: WHO, 1975), http://apps.who.int/iris/bitstream/10665/62873/1/14549_eng.pdf.

5 Ibid.

6 Ibid.

### Table 1: International Sanitary Conferences

| Year | Event |
|---|---|
| 1851 | 1st International Sanitary Conference |
| 1859 | 2nd International Sanitary Conference |
| 1866 | 3rd International Sanitary Conference |
| 1874 | 4th International Sanitary Conference |
| 1881 | 5th International Sanitary Conference |
| 1885 | 6th International Sanitary Conference |
| 1892 | 7th International Sanitary Conference (and first ratified Convention) |
| 1893 | 8th International Sanitary Conference |
| 1894 | 9th International Sanitary Conference |
| 1897 | 10th International Sanitary Conference |
| 1902 | 1st International Sanitary Convention of the Americas – mandated International (later Pan-American) Sanitary Bureau |
| 1903 | 11th International Sanitary Conference (agreed Convention replacing those of 1892–97) |
| 1905 | 2nd International Sanitary Convention of the Americas (initiated first Pan-American Sanitary Code) |
| 1908 | Establishment of Office International d'Hygiène Publique (OIHP) |
| 1912 | International Sanitary Convention (replacing 1903 Convention) |
| 1920 | League of Nations established temporary Epidemics Commission |
| 1923 | League of Nations established Health Committee and Advisory Council (appointed by OIHP) |
| 1924 | Pan-American Sanitary Code established as treaty (including defining role of Pan-American Sanitary Bureau) |
| 1926 | International Sanitary Convention (replacing 1912 Convention) |
| 1947 | Constitution of Pan American Sanitary Organization agreed |
| 1948 | World Health Organization founded |

The 1881 conference was held in Washington and was the first to include the United States along with seven Latin American countries as well as Haiti, Hawaii, China, Japan and Liberia. The American interest in these conferences was sparked by an act just passed that required a ship bound for the United States to be inspected and certified by a US consular official prior to departure from its home port. For that reason, the US government was authorized by Congress to convene a conference to secure an international system of notification consistent with the objectives of the act. Again very little came of this conference, but one notable proposal made was for an International Sanitary Agency of Notification with one office in Vienna and one in Havana.

In the end it was the 1892 conference that first delivered a treaty 'of very little scope governing maritime quarantine regulations relating only to cholera and only to westbound shipping from the East'.[7] Subsequent conventions were agreed in the following conferences, which were finally consolidated into one convention at the 11th conference in 1903 covering cholera, plague and yellow fever.

7 Ibid.

These series of conferences, other than that of 1881, were essentially European-led. In parallel there developed an American-led initiative stimulated in 1901 by the Pan American Union, the forerunner of the Organization of American States (OAS), which proposed that American health administrations be convened to reduce quarantine requirements to a minimum and to establish an International Sanitary Bureau. Thus the First General Sanitary Convention of the Americas met in 1902 and duly established the bureau, which was initially hosted by the US Public Health Service. Later renamed the Pan American Sanitary Bureau (PASB) and then the Pan American Sanitary Organization (PASO), this was the origin of what is now the Pan American Health Organization (PAHO).

## Office International d'Hygiène Publique and the League of Nations Health Organization

The convention agreed at the 1903 conference mandated the French government to propose the establishment of an 'international health office at Paris'. In 1907 a conference in Rome agreed on statutes for this new organization – the Office International d'Hygiène Publique (OIHP), one of the two forerunners of the World Health Organization. The principal object of the office would be to collect and disseminate facts and documents of general public health interest, particularly relating to cholera, yellow fever and plague. The OIHP, as it established itself, extended its interests well beyond this narrow mandate to include such topics as water purification and rat-infestation in ships, as well as a wide spectrum of other infectious diseases. A major task was the administration of and revision of the international sanitary conventions, and it was principally responsible for the revisions to the 1903 convention agreed in 1912, and later the convention of 1926 which replaced that of 1912.

The short life of the OIHP was interrupted by the First World War and then, after the war, complicated by the emergence of the new League of Nations with a mandate in its covenant to 'endeavour to take steps in matters of international concern for the prevention and control of disease'. The logical approach of using the OIHP as the basis for a proposed League of Nations Health Organization was stymied by the fact that the United States was a member of the former but not the latter. Ultimately a complicated system was evolved with the OIHP given an advisory capacity to the League's Health Organization. Thus two international health organizations and one strong regional organization in the Americas existed in some kind of symbiosis until the establishment of WHO after the Second World War under the aegis of the United Nations.

**Two international health organizations and one strong regional organization in the Americas existed in some kind of symbiosis until the establishment of WHO after the Second World War under the aegis of the United Nations**

In spite of these handicaps, the League's Health Organization considerably expanded the previous preoccupation with the spread of infectious diseases, particularly as the epidemics that followed the First World War subsided. Subjects taken up included immunization, standardization of diagnostic, prophylactic and therapeutic agents, nutrition, housing, physical fitness, cancer, public health training, hygiene and unification of pharmacopoeias. Thus had the agenda of international public health expanded from an almost exclusive focus on preventing the spread of infectious diseases to many of the wider public health concerns that are familiar today.

## Origins of the World Health Organization

At the United Nations Conference on International Organization in San Francisco in 1945, which drew up the UN Charter, the recommendation of the delegations of Brazil and China that 'a General Conference be convened within the next few months for the purpose of establishing an international health organization' was endorsed. A 16-member Technical Preparatory Committee was convened in March and April 1946. Drawing on memoranda from France, the United Kingdom, the United States and Yugoslavia, as well as inputs from the three pre-existing international health organizations and the United Nations Relief and Rehabilitation Administration (UNRRA),[8] the committee drew up in remarkably quick time an annotated agenda for the forthcoming conference, and a draft constitution for the proposed organization. Two issues were unresolved. One was the location of the organization. The other, which has resonated through the succeeding years, was whether existing regional organizations, of which the PASB was the most important example, should be an integral part of the new body or remain as autonomous institutions with close links with the headquarters body.

The subsequent International Health Conference, which lasted a month, was attended by 51 UN member states, 13 non-member states and a host of observers from other UN agencies, the pre-existing health organizations, and other important bodies such as the Red Cross and the Rockefeller Foundation. The conference agreed the constitution of WHO, the integration of the OIHP and the activities undertaken by the League's Health Organization and those of UNRRA devoted to health. It also established an Interim Commission to undertake urgent post-war work before WHO could be formally established following ratification by 26 member states. This was achieved in April 1948, and the First World Health Assembly (WHA) was convened in Geneva in June 1948.[9]

8 Created in 1943.

9 This and the preceding section is largely based on the account in WHO, *The First Ten Years of the World Health Organization*.

# 3. THE FIRST 40 YEARS OF WHO

## The constitution

The constitution of the World Health Organization is notable for the scope and breadth of the agenda it set for the new organization, in sharp contrast to the very restricted scope of the international sanitary conventions. This scope is defined in the preamble to the constitution (Box 1). It contains a very wide definition of the meaning of health, incorporating 'mental and social wellbeing'. Consistent with the high ideals of the UN Charter, it asserts that the 'highest attainable standard of health' is a fundamental human right. Health is also fundamental to peace and security. A distinguishing feature is the recognition that health is dependent not just on the provision of health services, including those unrelated to communicable diseases, but also on 'social measures'.

**A distinguishing feature of the constitution is the recognition that health is dependent not just on the provision of health services, including those unrelated to communicable diseases, but also on 'social measures'**

### Box 1: Preamble to WHO Constitution

THE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.
- The achievement of any State in the promotion and protection of health is of value to all.
- Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.
- Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
- Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.
- Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

Source: WHO Constitution, http://www.who.int/governance/eb/who_constitution_en.pdf.

### Box 2: Article 2 of WHO Constitution: Functions of WHO

In order to achieve its objective, the functions of the Organization shall be:

(a) to act as the directing and co-ordinating authority on international health work;
(b) to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate;
(c) to assist Governments, upon request, in strengthening health services;
(d) to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments;
(e) to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories;
(f) to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services;
(g) to stimulate and advance work to eradicate epidemic, endemic and other diseases;
(h) to promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries;
(i) to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene;
(j) to promote co-operation among scientific and professional groups which contribute to the advancement of health;
(k) to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective;
(l) to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment;
(m) to foster activities in the field of mental health, especially those affecting the harmony of human relations;
(n) to promote and conduct research in the field of health;
(o) to promote improved standards of teaching and training in the health, medical and related professions;
(p) to study and report on, in co-operation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security;
(q) to provide information, counsel and assistance in the field of health;
(r) to assist in developing an informed public opinion among all peoples on matters of health;
(s) to establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices;
(t) to standardize diagnostic procedures as necessary;
(u) to develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products;
(v) generally to take all necessary action to attain the objective of the Organization.

Source: WHO Constitution, http://www.who.int/governance/eb/who_constitution_en.pdf.

The objective of WHO (Article 1) was simplified to the 'attainment by all peoples of the highest possible level of health' but Article 2 reflected again the very wide-ranging functions envisaged for the organization (see Box 2). In essence, the new organization was asked to perform a multiplicity of tasks of which the first was the direction and coordination of international health work (a, b). The other principal functions may be categorized as follows:

- Technical assistance and emergency aid (c,d,e);
- Normative work (f,k,o,q,s,t,u); and
- Promoting and advocating for better health (f,g,h,i,j,l,m,n,p,q,r).

Specific functions include the ability to establish administrative and technical services (f), to propose conventions, agreements and regulations (k) and to promote and conduct research (n).

Apart from these functions, the constitution is also noteworthy for the scope of issues it sees as relevant to health including:

- Prevention of accidental injuries;
- Nutrition;
- Housing;
- Sanitation;
- Recreation;
- Economic or working conditions;
- Environmental hygiene;
- Maternal and child health and welfare;
- Mental health;
- Social security; and
- Informed public opinion.

Other notable features of the constitution included:

- The right to invite non-governmental organizations to participate in the World Health Assembly (Article 18);
- The right to adopt conventions or agreements (Article 19), regulations (Article 21) or recommendations (Article 23);
- Arrangements for regional organizations as integral parts of the organization (Articles 44–54);
- The right to accept gifts or bequests (Article 57);
- Obligations on members to report to the organization (Articles 61–65); and
- Arrangements for consultation and cooperation with non-governmental organizations (Article 71).

The contentious issue of regional organizations was resolved by the text agreed in Chapter XI of the constitution (see Box 3). Key points of this agreement were:

- Regional organizations would be integral parts of WHO;
- Each would have a regional committee, composed of member states, with its own rules of procedure and a regional office to execute its decisions;
- The head of the regional office would be the regional director appointed by the Executive Board (EB) in agreement with the regional committee; and
- The staff of the regional office would be appointed in a manner to be determined by agreement between the director-general and the regional director.

### Box 3: Chapter XI of WHO Constitution: Regional Arrangements

*Article 44*

(a) The Health Assembly shall from time to time define the geographical areas in which it is desirable to establish a regional organization.

(b) The Health Assembly may, with the consent of a majority of the Members situated within each area so defined, establish a regional organization to meet the special needs of such area. There shall not be more than one regional organization in each area.

*Article 45*

Each regional organization shall be an integral part of the Organization in accordance with this Constitution.

*Article 46*

Each regional organization shall consist of a regional committee and a regional office.

*Article 47*

Regional committees shall be composed of representatives of the Member States and Associate Members in the region concerned. [Text on territories omitted]

*Article 48*

Regional committees shall meet as often as necessary and shall determine the place of each meeting.

*Article 49*

Regional committees shall adopt their own rules of procedure.

*Article 50*

The functions of the regional committee shall be:

(a) to formulate policies governing matters of an exclusively regional character;

(b) to supervise the activities of the regional office;

(c) to suggest to the regional office the calling of technical conferences and such additional work or investigation in health matters as in the opinion of the regional committee would promote the objective of the Organization within the region;

(d) to co-operate with the respective regional committees of the United Nations and with those of other specialized agencies and with other regional international organizations having interests in common with the Organization;

(e) to tender advice, through the Director-General, to the Organization on international health matters which have wider than regional significance;

(f) to recommend additional regional appropriations by the Governments of the respective regions if the proportion of the central budget of the Organization allotted to that region is insufficient for the carrying-out of the regional functions;

(g) such other functions as may be delegated to the regional committee by the Health Assembly, the Board or the Director-General.

*Article 51*

Subject to the general authority of the Director-General of the Organization, the regional office shall be the administrative organ of the regional committee. It shall, in addition, carry out within the region the decisions of the Health Assembly and of the Board.

*Article 52*

The head of the regional office shall be the Regional Director appointed by the Board in agreement with the regional committee.

*Article 53*

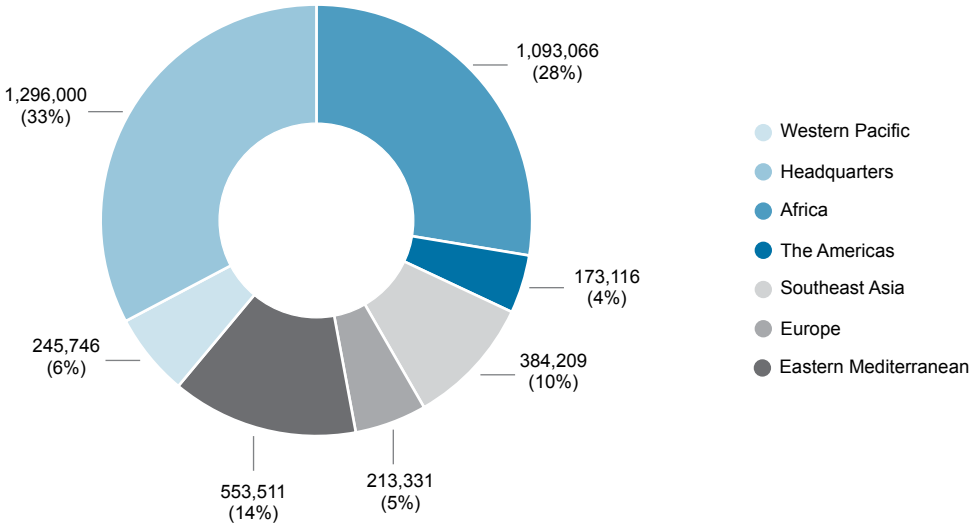
The staff of the regional office shall be appointed in a manner to be determined by agreement between the Director-General and the Regional Director.

*Article 54*

The Pan American Sanitary Organization represented by the Pan American Sanitary Bureau and the Pan American Sanitary Conferences, and all other inter-governmental regional health organizations in existence prior to the date of signature of this Constitution, shall in due course be integrated with the Organization. This integration shall be effected as soon as practicable through common action based on mutual consent of the competent authorities expressed through the organizations concerned.

Source: WHO Constitution, http://www.who.int/governance/eb/who_constitution_en.pdf.

**Figure 4: Budgets for the Regional Offices ($000)**




Source: http://www.who.int/about/resources_planning/programme_budget_2012_13/en/index.html.

As regards the Pan American Sanitary Organization (PASO), and all other intergovernmental regional health organizations in existence, they would in due course be integrated with WHO. This would be effected as soon as practicable through common action based on mutual consent of the competent authorities expressed through the organizations concerned. As it was, agreement was reached in 1949 whereby the Pan American Sanitary Conference, through the Directing Council of the PASO and the PASB, would serve respectively as the Regional Committee and the Regional Office of WHO.[10] But the agreement confirmed that each organization would also retain its own name and identity and that PASO could promote its own programmes in the western hemisphere provided they were compatible with WHO's policy and programmes and were separately financed. The latter point reflected the reality that PASO had an independent financial basis for its existence through direct contributions from its member states, and a close relationship with the Organization of American States. Even today, WHO's contribution to the total PAHO budget is under 25%, with the majority of funding coming from assessed member state and voluntary contributions as well as that contributed for PAHO's procurement activities.

## The early years (1948–73)

The first two decades or so of WHO's life have been characterized as cautious and technical.[11] There were political issues, not least the withdrawal of the communist-bloc countries in 1949, that lasted for nearly a decade. But for the most part WHO steered clear of controversial areas. A prime example was that of population – what is now generally called reproductive health. For its first decade or more the organization avoided the subject in deference to fierce opposition from predominantly Catholic nations that argued this was not a health issue. In the official WHO publication marking its first ten years there is not a single mention of this, even as a subject of debate.[12] As a result, developments in population policy took place elsewhere in the UN.

10 Basic Documents, 47th Edition. Agreements with other Intergovernmental Organizations, http://apps.who.int/gb/bd/PDF/bd47/EN/agreements-with-other-inter-en.pdf.

11 Walt, G., 'WHO Under Stress: Implications for Health Policy', *Health Policy* 24 (1994): 125–44.

12 WHO, *The First Ten Years of the World Health Organization*.

Similarly, controversy was apparently caused by WHO commissioning work that recommended social health insurance, arousing the ire of American doctors, among others.[13] These factors, and the overwhelmingly medical composition of its staff, naturally led WHO to concentrate on measures to combat diseases.

One of its first acts was to replace the existing International Sanitary Conventions by drawing up new International Sanitary Regulations, utilizing Article 21 of the constitution.[14] These were agreed in 1951, entered into force in 1952 and have subsequently been revised several times, including in 1969 when they were renamed the International Health Regulations.

**The eradication of smallpox was initially rejected by member states as being too difficult and too complex – ironic given that it was to prove one of WHO's greatest achievements**

In this period, therefore, WHO was probably best known for its efforts to control and eradicate particular diseases. The first, and the most expensive, was the campaign to eradicate malaria. This had initial success in some places and was expanded, particularly through massive US funding, on the theory that eradication needed to be achieved through treatment and vector control before resistance could take a hold. However, by the late 1960s as it became clear that malaria was resurgent, resistance had emerged, as had concerns about the use of DDT. Funding had tailed off and new strategies were needed.[15] The malaria story remains, of course, central to current concerns in WHO.

The eradication of smallpox was initially rejected by member states as being too difficult and too complex – ironic given that it was to prove one of WHO's greatest achievements. But a successful eradication programme in the Soviet Union in the 1950s changed minds. Even so, funding for smallpox eradication was initially difficult to come by, particularly in competition with the massive funds going into malaria. But ultimately WHO was successful in eradicating smallpox in a relatively short space of time – from the creation of the Intensified Smallpox Eradication Programme in 1967 to the last naturally occurring case of the disease a decade later.[16] This success led some to accuse WHO of 'eradicationitis' – seeking to eradicate diseases where the technical means to do so were not in place (malaria being a good example). Typically also disease-specific campaigns of this nature were and are criticized for being 'top down' and 'vertical' and detracting from the development of horizontally integrated health service development.[17]

In the context of current debates on the use of voluntary contributions, it needs to be noted that these eradication programmes were only financed by supplementing WHO's regular budget with extrabudgetary funds. Thus, as early as 1955, the World Health Assembly in resolution WHA8.30 established the Malaria Eradication Special Account.[18] By the end of 1960, this

13 Fulop, T. and Roemer, M., *International Development of Health Manpower Policy* (Geneva: WHO, 1982), http://whqlibdoc.who.int/offset/WHO_OFFSET_61_(part1-2).pdf.

14 It is commonly said that these regulations are the only ones under Article 21. In fact the first regulations, on Nomenclature relating to Diseases and Causes of Death, were agreed at the first World Health Assembly in 1948.

15 Godlee, F., 'WHO's Special Programmes: Undermining from Above,' *British Medical Journal*, 310 (1995), 310: 178–82, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2548565/pdf/bmj00576-0046.pdf.

16 Lee, K., *The World Health Organization (WHO)* (Abingdon: Routledge, 2009).

17 Godlee, 'WHO's Special Programmes'.

18 World Health Organization. Woorld Health Assembly Resolution WHA8.30, May 1955, http://whqlibdoc.who.int/wha_eb_handbooks/9241652063_Vol1_(part1-2).pdf.

account had received $12.7 million in voluntary contributions, of which the United States had provided $11 million.[19] At that time (1960) the regular budget stood at $15.1 million and WHO's total budget, including voluntary contributions from various sources, amounted to $25 million. Also in 1960 the WHA decided to establish a Voluntary Fund for Health Promotion, which consolidated all the existing special accounts established for voluntary contributions. Those accounts included those for the programmes on cholera, smallpox, leprosy, yaws and malaria.

**Disease-specific campaigns were and are criticized for being 'top down' and 'vertical' and detracting from the development of horizontally integrated health service development**

It is apparent that from the early days member states had always envisaged that WHO's regular budget would need to be supplemented to enable it to undertake special programmes, notably those to control and eliminate major diseases.[20] A detailed analysis of the smallpox eradication programme suggests that between 1967 and 1979 expenditure from WHO's regular budget for this purpose amounted to $33.6 million and that about $40.3 million consisted of voluntary contributions channelled through the Voluntary Fund for Health Promotion.[21]

Overall, WHO's budget expanded extremely rapidly in these years. Assessed contributions rose from $4.1 million in 1950 to $47.8 million in 1967. In the same period WHO's total income rose from $6.3 million to $72.2 million.[22]

## The changing nature of WHO (1973–88)

In its first 25 years the World Health Organization had only two directors-general, Brock Chisholm from Canada (1948–53) and Marcolino Candau from Brazil (1953–73). This relative stability in leadership and in WHO's focus on disease control and eradication was gradually changed under the influence of a number of factors. Not least of these was the rapid evolution of the membership (see Figure 5). Numbers increased from 55 states in 1948, to 85 in 1957, 126 in 1967, 146 in 1977, 178 in 1992 and 194 in 2012, reflecting the rapid progress of decolonization, particularly in the 1960s.

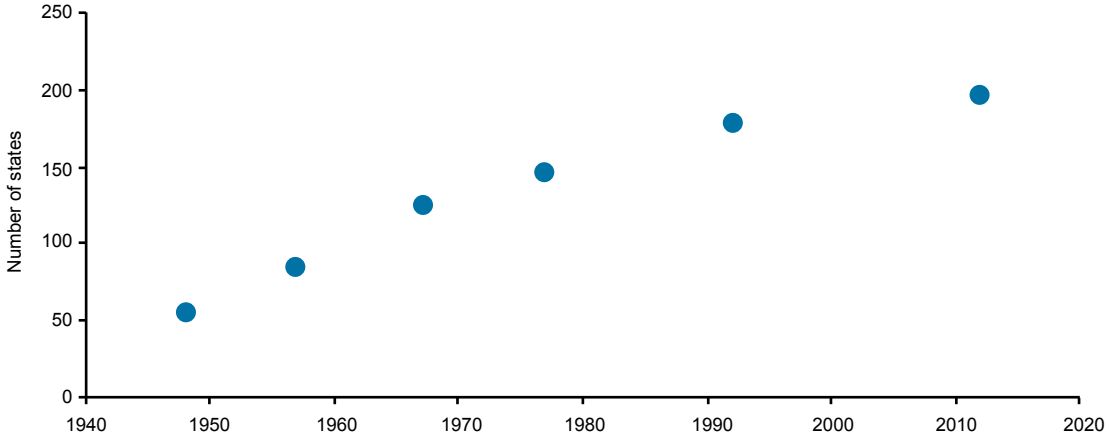
19 Malaria Eradication Special Account. Report by the Director-General', A14/AFL/22, 25 January 1961, http://whqlibdoc.who.int/eradication_stamps/A14_AFL_22.pdf.

20 World Health Organization, *The Second Ten Years of the World Health Organization 1958–1967* (Geneva WHO, 1968), http://whqlibdoc.who.int/publications/14564.pdf.

21 Fenner, F. et al., *Smallpox and Its Eradication* (Geneva: WHO, 1988), http://whqlibdoc.who.int/smallpox/9241561106.pdf.

22 WHO, *The First Ten Years of the World Health Organization*; and *The Second Ten Years of the World Health Organization, 1958–1967*.

**Figure 5: Evolution of WHO membership**




Source: http://www.who.int.

One result was increased pressure for WHO to emphasize its technical assistance over its normative role. In 1976 a resolution (WHA29.48) expressed concern 'with the gap between the health levels of the developed and developing countries' and asked the director-general 'to reorient the working of the Organization with a view to ensuring that allocations of the Regular Programme Budget reach the level of at least 60% in real terms towards technical cooperation and provision of services by 1980'.[23] The director-general noted 'that in approving the draft resolution, the Committee … had taken one of the most important political decisions in the history of the Organization'. In implementing it he said WHO should demonstrate

> *unity of purpose between the World Health Assembly, the Executive Board, Member States and the Secretariat. Such cohesion must exist between all levels of the Organization, between headquarters, regional offices and the field, and between regions. The Organization must never become a federation of six distinct regions with some vague entity at the central level as that would spell the end of WHO.*[24]

At the same time, the 1970s were characterized by massive economic transformation, notably epitomized by the impact of the 1973 oil shock, and by fundamental, if conflicting, changes in thinking about development. On the one hand, there was a strain of thought that ultimately led to the adoption by the World Bank and other agencies of the structural adjustment approach to lending, with its emphasis on fiscal and monetary stabilization. On the other hand, the 1970s also saw the birth of the basic-needs approach to development (articulated at the 1976 World Employment Conference of the International Labour Organization) and ideas for a New International Economic Order adopted by the UN General Assembly in 1974. In 1975 WHO and UNICEF published a document on meeting basic health needs; a flavour of its message and ambition is provided in its conclusion:

> *A firm national policy of providing healthcare for the underprivileged will involve a virtual revolution in most health service systems. It will bring about changes in the distribution of power, in the pattern of political decision-making, in the attitude and commitment of health professionals and administrators … To achieve such far-reaching changes, political leaders will have to shoulder the responsibility of overcoming the inertia or opposition of the health professions and other well-entrenched vested interests.*[25]

23 WHA29.48, 17 May 1976, http://hist.library.paho.org/english/GOV/CD/26340.pdf.

24 Quoted in World Health Organization, *The Third Ten Years of the World Health Organization 1968–1977* (Geneva: WHO, 2008), http://www.who.int/global_health_histories/who-3rd10years.pdf.

25 World Health Organization/UNICEF, 'Alternative Approaches to Meeting Basic Health Needs in Developing Countries. A Joint UNICEF/WHO Study', Geneva, 1975, http://whqlibdoc.who.int/publications/9241560487.pdf.

In this kind of radical approach one sees the influence of the new director-general, Halfdan Mahler, who served three terms from 1973 to 1988. He had spent the majority of his career both in WHO and in a single disease programme (tuberculosis) but is best known for championing the concept of 'health for all' in opposition to the disease-focused, vertical model – probably as a result of his experiences in the tuberculosis programme, where he advocated integrated service delivery.[26] In his first annual report in 1973 he recorded his view that 'the most significant failure of WHO as well as of Member States has undoubtedly been their inability to promote the development of basic health services and to improve their coverage and utilization'.[27]

**Health for All was not so much seen as a technical change in the means by which health care should be delivered to greater effect but as part of a more fundamental economic and social restructuring to reflect the aspirations of developing countries**

The Soviet Union was the principal proponent of a conference on the development of health services, although Mahler was initially opposed to such a meeting. As discussions in WHO progressed, the conference topic became focused on primary health care (PHC) and it was to be jointly sponsored by WHO and UNICEF. In 1977 the World Health Assembly in a resolution (WHA30.43) on technical cooperation decided 'that the main social target of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life' and requested

> *the Executive Board and the Director-General to pursue the reorientation of the work of WHO for the development of technical cooperation and transfer of resources for health in accordance with one of the Organization's most important functions as the directing and coordinating authority in international health work.*[28]

This reorientation of WHO's approach culminated in the 1978 International Conference on Primary Health Care, which agreed the Declaration of Alma-Ata (Box 4). The declaration emphasized that WHO's objective, i.e. 'the attainment of the highest possible level of health' required economic and social development 'based on a New International Economic Order' to reduce 'the gap between the health status of the developed and developing countries'. In turn, PHC was the key to attaining to the target of 'Health for All' by 2000. It was not so much seen as a technical change in the means by which health care should be delivered to greater effect but as part of a more fundamental economic and social restructuring to reflect the aspirations of developing countries.

In 1981, the WHA adopted the 'Global Strategy for Health for All by the Year 2000'.[29] In the years that followed, debates about the strategy were fierce, and indeed are relevant to today's renewed emphasis on universal health coverage. Strands of this debate were economic – if resources are limited, how can Health for All be delivered? This led to the strategy of selective PHC, which was enthusiastically embraced by UNICEF under James Grant and achieved success in attracting donors, in particular because of the emphasis on targeted results-oriented vertical interventions (e.g. oral rehydration, breastfeeding, vaccination). This in turn resulted in

26 Raviglione, M. and Pio, M., 'Evolution of WHO Policies for Tuberculosis Control, 1948–2001'. *The Lancet*, 359 (2002): 775–80.

27 World Health Organization, 'The Work of WHO 1973', Official Records of the World Health Organization, No. 213, Geneva, 1973.

28 WHA30.43, http://whqlibdoc.who.int/wha/1977/WHA30.43_eng.pdf.

29 World Health Organization, 'Global Strategy for Health for All by the Year 2000' (Geneva: WHO, 1981), http://whqlibdoc.who.int/publications/9241800038.pdf.

intensified institutional rivalry between UNICEF and WHO, which remained firmly committed to the Health for All concept. Also, for some donors the political rhetoric around Health for All, with its Cold War overtones, was not to their taste.

### Box 4: Extracts from Declaration of Alma-Ata

I. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II. The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III. Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

V. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII. Primary health care:

…

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

…

Source: World Health Organization, 'Primary Health Care: Report of the International Conference on Primary Health Care. Alma-Ata, USSR, 6–12 September 1978', Geneva, 1978, http://whqlibdoc.who.int/publications/9241800011.pdf.

The other distinguishing feature of the Mahler period, consistent with the broader interpretation of health expressed at Alma-Ata, was a willingness to expand the boundaries of WHO's concerns and, importantly, to confront powerful interests. As in the later case of tobacco, WHO's interest in breast-milk substitutes was stimulated particularly by an NGO campaign – and notably War on Want's 1974 publication 'The Baby Killer' – although there had been long-standing concern about their use among the medical profession in the developed world. In 1974 the World Health Assembly asked WHO to review the problem and propose remedies and in 1979 a WHO/UNICEF meeting called for an international code on marketing of infant formula. Against fierce industry lobbying the WHA agreed in 1981 the International Code on the Marketing of Breast-milk Substitutes, with only the United States voting against on the grounds that it was inappropriate for WHO to be involved in the regulation of private industry.[30] In forwarding the draft code to the WHA, WHO's Executive Board had debated whether it should recommend adoption as a stronger convention (Article 19 of the constitution) or regulation (Article 21) but decided, in the interests of generating unanimity (unsuccessfully, as it transpired), to go for the weaker form of recommendation (Article 23).[31] The United States reversed its position in 1994 by agreeing to Resolution 47.5 on infant and young child feeding.[32]

WHO also engaged in a sometimes fraught dialogue with industry and some governments in developing its policies on pharmaceuticals, in particular in drawing up in 1977 the first Model List of Essential Medicines, which was vigorously opposed by the pharmaceutical industry as a potential threat to their markets.[33]

Thus Mahler's era is remembered principally for the Health for All concept, which resonates today in the slogan of universal health coverage. As noted above, Health for All reflected a different way of approaching health care as much as a numerical target. Mahler set out his manifesto at considerable length in a WHO journal in 1981. His views on the wider value of investing in health contrast strongly with the paradigm developed later that was embraced by Brundtland, as described below. Mahler wrote:

> *Classical economics too is in danger of estranging itself from the aims of society by confusing economic growth with development and by constantly demanding economic proof of social benefits. Can these benefits really always be expressed in economic terms? Surely it is the other way round: development has to be proved in social terms. It has to be capable of augmenting the energies of the people, stimulating their creativity, and raising the quality of life. The greatest potential energy in the world is human energy, and health is the fuel that can generate it.*[34]

## The evolving wider landscape in global health

It is ironic that at the very same time the World Health Organization was putting in place the Health for All strategy, the World Bank was developing two policies that would fundamentally transform the landscape in which the organization operated.

Although the Bank had previously been involved with lending for population and family planning, in 1979 it established a Population, Health and Nutrition Department and in 1980 published a Health Sector Policy Paper that committed it for the first time to direct lending in

30 Reich, M.R., 'Essential Drugs: Economics and Politics in International Health', *Health Policy*, 8 (1987): 39–57, http://e.hsph.harvard.edu/faculty/michael-reich/files/essential_drugs.pdf.

31 World Health Organization, 'International Code of Marketing of Breast-milk Substitutes' (Geneva: WHO, 1981), http://www.unicef.org/nutrition/files/nutrition_code_english.pdf.

32 International Lactation Consultant Association, 'The International Code of Marketing of Breastmilk Substitutes: What It Means for Mothers and Babies Worldwide', 2001, http://www.ilca.org/files/education_and_research/independent_study_modules/ILCA%20documents/Doc%20%20International%20Code-Document.pdf.

33 Reich, 'Essential Drugs'.

34 Mahler, H., 'The Meaning of "Health for All by the Year 2000"', *WHO Health Forum*, 2(1)(1981): 5–22, http://whqlibdoc.who.int/whf/1981/vol2-no1/WHF_1981_2(1)_(p5-45).pdf.

the health sector, focusing on the need for basic health services, especially in rural areas, and the links between the health sector, poverty alleviation, and family planning.[35] This continued a transformation of the World Bank, largely under the leadership of Robert McNamara, from an institution that principally invested in physical infrastructure in the 'economic' sectors to one that, while still emphasizing infrastructural investment, encompassed the 'social' sectors as important contributors to development.

**The challenge to WHO lay in competition in the sphere of policy where World Bank thinking, grounded in macroeconomics and neo-liberal ideas, was a sophisticated response to WHO's position, grounded in the thinking of health professionals as exemplified by Health for All**

In parallel with this development was the decision in 1979 to introduce structural adjustment lending which, *inter alia*, led to a prolonged and even continuing controversy about whether or not the policy measures required under structural adjustment programmes unduly restricted investment in social sectors, in particular health care. The advocacy of cost recovery policies in health care was particularly controversial.[36] Within a decade the World Bank was lending a multiple of WHO's annual budget to the health sector, and a multiple of that lending on structural adjustment. The challenge to WHO was not principally about the disparity in financial clout – this was a contest WHO was never intended to enter. Rather, the challenge lay in competition in the sphere of policy where World Bank thinking, grounded in macroeconomics and neo-liberal ideas that later became known as the Washington Consensus, was a sophisticated response to WHO's position, grounded in the thinking of health professionals as exemplified by Health for All. Moreover, the World Bank was in a strong position to influence borrowing countries and the wider development community based on its position as the premier global development bank and its reputation as a promoter of policy ideas based on its strong analytical capacity, albeit principally in economics. Its 1993 World Development Report, 'Investing in Health', was particularly influential, in particular in the way it later influenced WHO policies under Brundtland.

35 World Bank Group, HNP Timeline, http://siteresources.worldbank.org/EXTWBASSHEANUTPOP/Resources/appA.pdf.

36 De Ferranti, D., 'Paying for Health Services in Developing Countries. An Overview', Staff Working Paper No. 721 (Washington, DC: World Bank, 1985), http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2003/06/14/000178830_98101903430786/Rendered/PDF/multi0page.pdf.

## 4. WHO REFORM (1989–98)

Although the functioning of WHO had been reviewed in various ways from its very early days, serious consideration of the need for reform began in the late 1980s and early 1990s, stimulated in part by more general concerns about the whole UN system. These had become evident long before in 1964 when the Geneva Group of 11 major contributors to the UN was formed to restrain the growth of agency budgets.[37] By 1984 they had largely achieved the aim of restricting the growth of agency budgets to zero in real terms, including for WHO. The use of this blunt instrument was a reflection of the difficulty in achieving changes in performance and accountability of the UN system, so budget restriction was the second-best policy in their eyes. Paradoxically this simply shifted donors' interest to ways in which they could achieve their objectives for WHO through voluntary contributions usually earmarked for the pursuit of particular programmes they promoted or favoured.

### Nordic and Danish reports

The UN Nordic Project was established by the governments of Denmark, Finland, Norway and Sweden in 1988 to consider possible reforms to the wider UN system. A background study of the UN specialized agencies[38] focused on two major issues at WHO. These were:

- The increasing role of special programmes financed by voluntary contributions outside the regular budget, and the lack of accountability of such programmes to the World Health Assembly, and the potential distortions to regular budget spending arising from them; and
- A perceived decline in WHO's analytical capacity as a result of increased emphasis on technical assistance programmes and a consequential decline in the relevance of WHO to industrialized countries. The study therefore recommended scaling back WHO's role as an executor of projects and strengthening its normative and analytical functions in areas of global importance.

At a similar time the Danish development agency, DANIDA, reviewed the effectiveness of multilateral agencies, including WHO, at country level.[39] It highlighted the following issues:

- Weak country-level performance as a result of insufficient capacity and authority and the effects of a politicised regional bureaucracy;
- A lack of strategic planning and ad hoc resource allocation dominated by political considerations;
- Absence of skills in respect of health policy, economics and management; and
- A contradiction between a focus on vertical programmes and the wider advocacy by WHO of integrated primary health care, which undermined its leadership role.[40]

37 Overseas Development Institute, 'The UN and the Future of Multilateralism', Briefing Paper, London, October 1987, http://www.odi.org.uk/resources/docs/6728.pdf.

38 Edgren, G. and Moller, B., 'The Agencies at a Crossroads: the Role of United Nations Specialized Agencies', in *The United Nations: Issues and Options*, Nordic UN Project (Stockholm: Almqvist och Wiksell, 1991).

39 Cowiconsult, 'Effectiveness of Multilateral Agencies at Country Level', DANIDA, 1991.

40 The above summaries of the Nordic and DANIDA studies are taken from Chen L., Bell D. and Bates L., *World Health and Institutional Change in Pocantico Retreat: Enhancing the Performance of International Health Institutions* (Cambridge, MA: Harvard, Rockefeller Foundation, 1996).

## Joint Inspection Unit report

Also in 1993, the UN Joint Inspection Unit (JIU) published a report on WHO as part of a study on 'Decentralization of Organizations within the United Nations System'.[41] This report focused on WHO's unique regional structure and asked whether it fostered 'the most economical and efficient use of its programme, budgetary and staff resources, which are limited relative to the magnitude of needs in the Member States.' It drew on a number of assessments over the years including, for instance, this by the director-general in 1979, who noted:

> *the widening gap that has grown between policy and practice in WHO, linked closely to the question of centralism versus decentralism … the central organs of WHO have become nominally stronger, but have little control over the bulk of the Organization's activities, namely those that take place in the regions and countries. The regional structures, too, have become stronger and more independent, yet have tended to concentrate on intercountry activities and have little control over the Organization's activities in countries and little influence in shaping overall policy.*

Having reviewed various assessments and evaluations including that of DANIDA quoted above, it concluded 'that, while the three-layer organizational structure appears excellent as described in the Constitution and official documents, its actual functioning is beset by serious and complex problems of a constitutional, political, managerial and programmatic nature'.

**A 1993 report on WHO concluded 'that, while the three-layer organizational structure appears excellent as described in the Constitution and official documents, its actual functioning is beset by serious and complex problems of a constitutional, political, managerial and programmatic nature'**

It stressed that 'courageous reforms' were necessary if WHO were to achieve its 'vast potential'. It identified a central problem was the way regional directors (RDs) were elected by their Regional Committees because of the following weaknesses:

> *(a) The independence of RDs* vis-à-vis *the Director-General (DG), with the consequent exacerbation of underlying centrifugal forces within the Organization;*
>
> *(b) some RDs might tend to view their status and role in political rather than in technical terms, with the consequent undue politicization of an organization which should prize technical pre-eminence;*
>
> *(c) possible political debts owed by the RDs to their electors and which cannot be paid without some prejudice to the integrity of the Organization's policies, regulations and rules;*
>
> *(d) likely diversion of resources and time from health advocacy and leadership to the search for electoral support;*
>
> *(e) some RDs might be tempted to consider themselves more as servants of their regional electorates than as servants of the Organization as a whole within their respective regions;*

41 Joint Inspection Unit, 'Decentralization of Organizations within the United Nations System. Part III: The World Health Organization', Geneva, 1993, http://www.unjiu.org/data/reports/1993/EN93-02.PDF.

*(f) the absence of a structured working relationship between the RDs and other ungraded officials in headquarters who are directly appointed by the DG, especially the Deputy DG.*

On the basis of that analysis the report suggested that the Executive Board should reassert its constitutionally derived authority over the whole of WHO and, as part of that, the qualifications and level of representatives to the Regional Committees should be reviewed 'to ensure that they are more technically-oriented than politically-oriented'.

It also made the following recommendations:

*(a) The Director-General should be empowered to select and nominate RDs for confirmation by the Executive Board, following consultations and in agreement with the regional committees concerned or their Bureaux;*

*(b) the selection and consultation processes should be handled confidentially by the DG to preclude any open competition for the RD position;*

*(c) if, as recommended earlier, the qualifications and level of Regional Committee representatives are altered to emphasize concern for implementation issues, such a change, combined with the new method proposed above for selecting RDs, would require them to become technical managers in a more conventional sense, i.e. fully involved, non-political, hands-on managers of their regional programmes, a role very similar to that now performed in the regional offices by the Director of Programme Management (DPM). This position could consequently become duplicative, if not redundant, and might therefore be abolished. if applied to all six regional offices, the proposed measures would yield estimated savings upwards of US$1.7 million each biennium, which may be judiciously used, for example, to strengthen WHO's presence in the least developed countries;*

*(d) the term of office for all RDs, including the RD for AMRO/PAHO, should be five years, renewable once. This recommendation could also apply to the term of office of the DG;*

*(e) the RD post description should be modified to allow for substantial decentralization of some of their authority and functions to WHO Country Representatives in country programme management, administration and resource mobilization;*

*(f) whether or not these proposals justify a review of the grading of RD positions is left to the discretion and wisdom of the Board.*

This was therefore a proposal to attempt the depoliticization of regional committees and to reassert the *de jure* authority of the Executive Board and director-general in the appointment of regional directors. The JIU report believed that these changes were possible without amending WHO's constitution.

Although little seems to have happened as a result of the report, it is of interest that a review of its findings has been requested as part of the current reform process (see section 6 on Current Reform below).

## 'Oslo' studies

A consortium of donors financed a number of studies of WHO in the mid-1990s, in particular on the issue of extrabudgetary funds (EBFs) and country-level programmes. The study on EBFs, financed by the governments of Australia, Norway and the United Kingdom, came to rather positive conclusions about their impact, namely:

- *They have been of significant benefit to international health efforts for low-income countries.*

- *They have been instrumental in combating important health problems and the funds have been targeted against important disease burdens in these countries.*
- *They have been supportive in developing and implementing scientifically sound and acceptable health interventions and disease control strategies. When judged in general terms, they have achieved value-for-money for both the donor countries and WHO.*
- *There are, however, severe organizational challenges within WHO which limit the effectiveness and efficiency of many of WHO programmes that receive these funds.*[42]

The 'severe organizational challenges' are not fully described in the summary article – and elsewhere it notes that these programmes as a whole generally provide good value for money and that, to a large extent, donor priorities are well aligned with those of WHO. Thus the main concern raised is not EBFs themselves or whether WHO is donor-driven – on the whole the study thought that donor influence on WHO had been positive. Rather the concern was:

> *the lack of authority and leadership being exerted over the whole of the Organization by the WHO Assembly, Executive Board and Director-General, including over the use, distribution and accountability for all funds, both regular and extrabudgetary … The situation allows donors to say that many of WHO's problems are of its own making, whereas they are also an integral part of these same problems, such as in their failure to reconcile their own international health and aid policies … In these circumstances WHO does not have to remain passive. If it took the initiative and established firm and clear control over the whole Organization, including the EBFs, it would most likely incur the respect of the major donors. With confidence in the Organization restored, the contributions of extrabudgetary funds would probably increase and the Organization's funding could be re-established on a firmer footing. Thus donors have important responsibilities in supporting WHO's reforms, as well as it being in their own best interests.*[43]

The study also makes the point, as alluded to above, that whereas regular budget contributions usually come from the Ministries of Health (which take the lead at the World Health Assembly) extrabudgetary contributions are typically from Ministries of Foreign Affairs or development agencies and this is another source of possible disjunction between the priorities of these two funding streams.

**Another report said 'The situation allows donors to say that many of WHO's problems are of its own making, whereas they are also an integral part of these same problems, such as in their failure to reconcile their own international health and aid policies'**

A companion study, sponsored in addition by Canada, Italy and Sweden, reviewed country-level programmes.[44] A key finding was that WHO needed to tailor its role to the needs of particular countries – there was a very poor or negative correlation between a country's needs and the scale of WHO efforts. In many countries with the least capacity, WHO made a smaller

42 Vaughan, P. et al., 'WHO and the Effects of Extrabudgetary Funds: Is the Organization Donor Driven?', *Health Policy and Planning*, 11 (3)(1996): 253–64, http://heapol.oxfordjournals.org/content/11/3/253.full.pdf.

43 Ibid.

44 Lucas, A. et al., 'Cooperation for Health Development: The World Health Organization's Support to Programmes at Country Level', September 1997, http://whqlibdoc.who.int/publications/0N02657577_V1_(ch1-ch2).pdf; 'Cooperation for Health Development: WHO's Support to Programmes at Country Level. Summary', September 1997, http://www.norad.no/en/tools-and-publications/publications/publication?key=109668.

contribution than in better-resourced countries. The study proposed the concept of 'essential presence' based on a thorough analysis of a country's current needs and capacities. If there was a need for a WHO presence, then a time-limited contract should be negotiated defining the organization's role and responsibilities in relation to the government and other actors/donors. Such an arrangement should be regularly reviewed with a view to increasing a country's own responsibilities as its capacity increased. Among the study's 50 findings were:

- The lack of coordination of funding to countries between different levels of the organization, even completely independent of WHO country office.
- Processes and procedures to manage financial and human resources were fragmented and inefficient. Financial information on country spending was often absent.
- WHO could not respond to the needs of countries for advice on health sector reforms.
- WHO should be more selective in adopting the role of executive agency.
- Divergence between WHO policy set out by its governance bodies and practice at country level.
- Selection, recruitment training and management procedures were deficient and politically influenced. Consultants were often of poor quality.
- Past and present examples of poorly functioning WHO country representatives being left in place.
- Variations in autonomy granted to country representatives.
- Budgetary planning was lengthy and arduous.

## WHO response to Global Change Report

Within WHO the Executive Board formed a working group in 1992 to report on the 'WHO Response to Global Change'.[45] It noted that the end of the Cold War, a heightened emphasis on market-based solutions and also the decline in economic growth, and increased debt, had resulted in countries becoming 'increasingly preoccupied with health sector financing, particularly the sharply rising costs of medical care, which threaten the sustainability of cost-effective primary health care interventions'.

Although WHO had considerable achievements in its last two decades, 'rising health expectations, the pace of global change and WHO's expanding programme responsibilities are outpacing current resources and institutional capacity'. Recent efforts to attract resources to WHO had not been fully successful and other UN agencies or international bodies had increased their efforts in the health and environmental field. The involvement of other institutions in health-related initiatives was important but

> *it should not displace WHO's leadership of these initiatives. In order to maintain health sector leadership, WHO must strengthen its capabilities in epidemiological analysis, policy analysis and priority determination, programme planning and management, resource mobilization, management information systems, health research, international communications, and communications with the public.*

WHO's technical staff were of high quality. But there were several critical areas where further strengthening was required including:

45 'Report of the Executive Board Working Group on WHO Response to Global Change', EB92/4, 16 April 1993, http://hist.library.paho.org/English/GOV/CD/15660.pdf.

- Recruitment policies;
- Relative technical and managerial weaknesses of country representatives;
- Fragmented and compartmentalized management of global, regional and country programmes;
- Difficulties in rotating staff between headquarters and regions and between regions;
- Lack of comprehensive programmes for staff evaluation, training and development; and
- Underutilization of the personnel and technical capabilities of WHO collaborating centres.

WHO had demonstrated ingenuity in responding to 12 consecutive years of no real growth in its budget. Extrabudgetary resources had increased from about one-fifth of the budget in 1970 to more than half by 1990. But these resources had paradoxically created a financial drain on the regular budget, which had to subsidize the extrabudgetary administrative activities. It asserted that the actual overhead cost required to support programmes was approaching 35%, compared with the standard UN charge of 13%, meaning that the regular budget had to subsidize extrabudgetary programmes to the tune of 22% of their cost. In addition there were 'competing policy and budgetary considerations' arising between decisions of WHO governance bodies and the 'donor dominated management structures of the extrabudgetary supported programmes'.

The constitution envisaged the regional offices as integral components of WHO. But in practice:

> *the Organization is often described as 'seven WHOs': headquarters and the six regional offices. The Organization must avoid compartmentalization and fragmentation between headquarters, regions and countries, especially with regard to budgetary resource utilization, staff development, information systems, research and evaluation methods, and collaborative international health work.*

WHO had caught the world's attention with 'Health for All by the Year 2000'. Although this goal remained valid as a guiding principle, the organization and its member states had not been able adequately to finance and implement PHC programmes to ensure achievement of the targets. Either efforts had to be redoubled or the goals had to be revised to achievable levels.

The report made some detailed recommendations, mainly asking the Executive Board and/or the director-general to undertake reviews and studies to come up with better-defined policies and procedures. Recommendations included:

- Consideration of different ways to improve the workings of the Executive Board and World Health Assembly;
- Consideration of recruitment methods for the director-general and regional directors and the duration of their terms, including restricting them to one term only;
- Regional Committees to study their own method of work with a view to better harmonization with the rest of the organization;
- Consideration of how to improve country representatives' recruitment, training, skills, rotation, role in country leadership in respect of UN agencies and donors and their integration with the rest of WHO;
- Ways to establish WHO leadership in UN agency coordination on health-related matters; and
- EB representation on the management of extrabudgetary programmes and increasing the overhead rate for these programmes from 13% to up to 35%.

The Executive Board asked the director-general 'to prepare documents on the implementation of the recommendations of the Working Group'.

## WHO follow-up on Global Change

In the following years the Executive Board (EB) pursued a number of different avenues that came under the rubric of WHO reform. Thus in EB101 in January 1998 there was an agenda item under 'WHO reform' with three separate items: country offices, programme budget evaluation, and review of the constitution and regional arrangements.

WHO indicated that it had introduced 'many wide-ranging changes in its managerial processes in order to make its work more relevant and effective' as a result of the Global Change report.[46] A development team was created in on the future role of WHO at country level, which reported to successive EB sessions in the mid-1990s. One important aspect of the reform was an attempt to develop criteria for establishing WHO offices with the priority on countries with greatest need.[47]

Similarly, the Global Change report stimulated a stream of work on priority setting. An EB paper in October 1997 noted:

> *The need to set priorities for the Organization has been reinforced recently by the fact that resources are becoming increasingly scarce while the requirements of the Organization's Member States are growing along with demands for technical cooperation. A large number of resolutions have addressed the issue, though not in a holistic way. The report of the Executive Board Working Group on the WHO Response to Global Change placed emphasis on priorities and recommended that they should be coordinated at all levels of the Organization. The Executive Board reviewed a number of documents responding to these requests, such as 'Programme budgeting in WHO and prioritization of activities' [EB January 1995], and subsequently decided on a set of priorities for elaboration and implementation of the 1998-1999 programme budget [EB May 1996].*[48]

The EB also commissioned in 1995 (WHA48.14) a special group to examine whether all parts of the constitution remained appropriate and relevant to WHO's response to global changes and their implications, as well in view of the ongoing review of the Health for All policy. It was also asked 'to cover questions relating to WHO regional arrangements within the framework of the existing Constitution'.[49] The special group proposed a number of constitutional changes, including a fundamental rearrangement of Article 2 on functions that were reordered and adapted under five major headings:

- To act as the directing and coordinating authority on international health;
- To lead international health policy development;
- To serve as the international agency for setting and monitoring norms and standards in health;
- To cooperate with member states, primarily through national health administrations, and upon request, by providing advice and technical cooperation; and
- To act as the international advocate for Health for All.

Other changes were proposed or considered. For example, there was a debate in the group as to whether EB members should be designated in their personal capacity (as provided for in Article 24) or as governmental representatives, but it decided not to recommend change.

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46 'WHO Reform. WHO Country Offices. Report by the Director-General', EB101/5, 4 December 1997, http://apps.who.int/gb/archive/pdf_files/EB101/pdfangl/ang5.pdf.

47 Ibid.

48 'Programme Budgeting and Priority Setting. Analytical Framework for Setting WHO Priorities. Report by the Director-General', EB/101/24, 15 October 1997, http://apps.who.int/gb/archive/pdf_files/EB101/pdfangl/eb10124.pdf.

49 'WHO Reform: Review of the Constitution and Regional Arrangements of the World Health Organization. Report of the Special Group', EB101/7, 14 November 1997, http://apps.who.int/gb/archive/pdf_files/EB101/pdfangl/eb1017.pdf.

As regards its review of regional arrangements, it made the following points, among others:

- The implementation of reforms had progressed substantially at global level but progress at regional level had been uneven and should be monitored by regional committees. WHO's decentralization was an asset 'but an effort was needed to preserve the unity of the Organization'.
- Current budget allocations to regions were based on outdated historical precedents and 'more transparent and objective criteria based on needs at country level should be established'. It proposed three different scenarios based on different health and economic indicators by which allocations could be improved. No firm proposal was made. Some members suggested also that extrabudgetary resources should be a factor in regular budget allocations but others disagreed.
- The group recommended (with an air of frustration), in respect of Article 54 on future integration with PAHO, 'that in the light of the expectation of integration of PAHO and WHO, which had not been fully accomplished in 50 years, the Organization should examine with PAHO whether (a) the Article should be amended or deleted, or (b) integration should be completed'.
- It recommended that the number of seats on the Executive Board should be further increased by two to 34. The original size of the EB set in 1948 was 18 subsequently increased to accommodate the rapid increase in membership of WHO.
- It was proposed that the term of office of regional directors should be five years, renewable once, but not applicable to present incumbents, and that revised criteria for their selection and appointment should be applied. The group did not favour allowing the EB to choose regional directors from more than one candidate proposed by the regional committees.

With the exception of the expansion of the Executive Board, these proposals were not pursued in the form proposed when Gro Harlem Brundtland took office in 1998.

## 5. THE BRUNDTLAND YEARS (1998–2003)

*The Economist* quote at the beginning of this paper indicates that whatever attempts were made at reform in the era of Hiroshi Nakajima as director-general (1987–98) were largely nullified by the various shortcomings attributed to him. An earlier set of six critical articles in the *British Medical Journal* about all aspects of WHO operations by Fiona Godlee, who is now its editor, culminated in a 1995 editorial titled 'WHO: Change or Die'.[50] The message was further pushed home in another editorial in 1997: 'WHO Reform and Global Health: Radical Restructuring Is the Only Way Ahead'.[51] Earlier still, in 1993, Gill Walt, an academic, had penned an influential article on WHO's travails.[52] In addition to this active and critical coverage in the specialist press, there were other initiatives. A key meeting at Pocantico (NY) in 1996, facilitated by the Rockefeller Foundation, brought together senior academics, NGOs, former and present WHO employees and others to discuss whether international health institutions were keeping up with the changes associated with globalization and the changing landscape in health, including the role of UN organizations other than WHO, the role of bilateral donors and, in particular, the growing role of the World Bank.[53] The meeting report contains a great deal of analysis of the issues but its principal conclusions are about process:

> *to create an independent expert group or commission, with a life of several years, charged with the mission of developing and advocating a series of immediate and long term reforms … [n]urture dialogue between the World Bank and outside interested parties to improve the Bank's future performance in health.*

In 1998 three prominent global health experts proposed a way to specify the necessary functions of international institutions. They summarized this as follows:

> *To improve the performance of international health organisations, their essential functions must be agreed. This paper develops a framework to discuss these essential functions. Two groups are identified: core functions and supportive functions. Core functions transcend the sovereignty of any one nation state, and include promotion of international public goods (eg, research and development), and surveillance and control of international externalities (eg, environmental risks and spread of pathogens). Supportive functions deal with problems that take place within individual countries, but which may justify collective action at international level owing to shortcomings in national health systems – such as helping the dispossessed (eg, victims of human rights violations) and technical cooperation and development financing. Core functions serve all countries, whereas supportive functions assist countries with greater needs. Focus on essential functions appropriate to their mandate will better prepare international health organisations to define their roles, eg for WHO to focus on core functions and for the World Bank to focus on supportive ones.*[54]

### Reforms[55]

In her first speech as director-general, Gro Harlem Brundtland set out her objectives for the World Health Organization. She said the 'world is in transition. So accordingly *WHO must be in transition*' (her emphasis).[56] WHO should therefore follow two roads:

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50 WHO Smith, R., 'WHO: Change or Die', *British Medical Journal*, 310 (1995): 543–44, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2548932/pdf/bmj00582-0005.pdf.

51 Godlee, F., 'WHO Reform and Global Health: Radical Restructuring Is the Only Way Ahead', *British Medical Journal*, 314 (1997): 1359–60, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2126641/pdf/9161300.pdf.

52 Walt, G., 'WHO Under Stress: Implications for Health Policy', *Health Policy*, 24 (1994): 125–44.

53 Rockefeller Foundation, Pocantico retreat, *Enhancing the Performance of International Health Institutions* (Cambridge, MA: Rockefeller Foundation, Social Science Research Council, Harvard School of Public Health, 1996).

54 Jamison, D. et al., 'International Collective Action in Health: Objectives, Functions, and Rationale', *The Lancet,* 351 (1998): 514–17, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(97)11451-9/fulltext?_eventId=login.

55 Jon Lidén's companion paper provides much useful colour and context to the Brundtland era.

56 Brundtland, G.H., 'Speech to the Fifty-first World Health Assembly Geneva', A51/DIV/6, 13 May 1998, http://www.who.int/director-general/speeches/1998/english/dgspeech%20wha98%20eadiv6.pdf.

> *One road leads to our work on the ground. We must combat disease, premature death and disability. We must give advice on best practices to achieve equity and quality, set standards and norms. We must encourage, support and trigger the best research and development.*
>
> *The other road leads to the levels of political decision-making where the broader agenda for development is set. We must speak out for health in development, bringing health to the core of the development agenda. That is where it belongs, as the key to poverty reduction and development underpinned by the values of equity, human dignity and human rights.*

To succeed in this endeavour it was necessary to demonstrate that

> WHO is one. [her emphasis] *Not two – meaning one financed by the regular budget and one financed by extrabudgetary funds. Not seven – meaning Geneva and the six regional offices. Not more than fifty – meaning the individual programmes. WHO must be one: Setting its priorities as one, raising additional financial resources as one, speaking out as one. And then – but only then – can we act effectively in our decentralized diversity through skilled presence at the country level, through regional guidance by the regional offices and through global direction by the headquarters and the governing bodies.*

She saw several basic requirements to make WHO the 'lead agency in international health'. But this position was not the organization's by right – it had to be earned, she said. WHO needed:

- A stronger partnership with member states – in particular improving the quality of work at country level and supporting health-sector development.
- To reach out to others – UN agencies, the multilateral development banks and the International Monetary Fund (IMF), NGOs and the private sector (including a WHO-industry roundtable).
- To underpin its work with solid facts – she would establish a separate function on Evidence for Health Policy. WHO needed to know the burden of disease and the cost-effectiveness of interventions to define its priorities. It needed evidence to demonstrate to decision-makers around the world, including prime ministers and finance ministers, that 'health investments are sound investments for poverty reduction and economic growth'.

She also mentioned two projects she wished to start implementing immediately: Roll Back Malaria and the Tobacco Free Initiative.

Upon her nomination in January 1998, Brundtland set about her task in a way that no other director-general had done. She set up a transition team (funded by the Norwegian government) under Jonas Støre, her close adviser when she was prime minister, to plan a rapid programme of change to take place immediately on her taking up the post in July. The core of the internal changes was the reorganization of WHO headquarters into clusters of departments each headed by an executive director (ED). The latter replaced the assistant directors-general (ADGs). Apart from the objective of rationalizing the internal structure, this change had several rationales:

- One idea was to move away from explicit political appointments at ADG level and to reassert the director-general's authority over these appointments (although she naturally had to apply her own criteria in terms of geographical and gender balance).
- As reflected in the change of name, the idea was to make EDs active managers of their clusters and owners of cluster activities rather than, as often seemed in the past with ADGs, figureheads who left the real work to their directors and staff below them. A corollary of this was that directors felt threatened and that authority over programmes had shifted to EDs less technically qualified in their particular specialisms.
- EDs would form the core of a cabinet, which would meet weekly and take collective decisions which each would support – an attempt to overcome the bureaucratic infighting that characterized WHO.

This internal governance structure was modelled to a considerable extent on Brundtland's experience in government with EDs being the equivalent of ministers (albeit supposedly technocratic ones) and directors the senior civil servants. As noted above, many directors resented this change, and in many cases lost their direct relationship with the director-general's office, which was an essential part of influencing resource allocation in the 'old' WHO.

To support this collective approach Brundtland also sought to build solidarity through organizing retreats for EDs, senior staff and regional directors, and with members of the Executive Board. She also instituted a Global Cabinet to bring the regional directors into the formulation of global strategies. Below this level the director-general sought to reduce the number of senior-level staff, which had expanded greatly under Nakajima, principally by reducing the number of departments, and to improve the gender balance. After only one year in office she noted that when she came to office only four out of more than 50 directors were women. A year later, 10 out of just 33 department directors were women.[57] Brundtland also devolved the central administrative units to clusters in Management Support Units (MSUs), to make the administration closer to the technical work, a move that was generally popular but was soon reversed for reasons that are unclear. And in subsequent years a corporate strategy was developed, which identified new ways of working:

- Adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;
- Playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;
- Triggering more effective action to improve health, and to decrease inequities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;
- Creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.[58]

The corporate strategy also identified four strategic directions:

1. Reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;
2. Promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes;
3. Developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands, and are financially fair;
4. Developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

The director-general noted that work had been initiated to enhance WHO's hitherto weak performance in respect of strategic direction 4.

In addition, core functions were identified around WHO's normative work, evidence-based policy and advocacy, technical and policy support, partnerships and technology development and testing. Project management and execution were singled out as lower-priority activities, and the need for procurement needed to be justified.

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57 Brundtland, G.H., 'Speech to the Fifty-second World Health Assembly', A52/3, 18 May 1999, http://apps.who.int/gb/archive/pdf_files/WHA52/ew3.pdf.

58 World Health Organization, 'A Corporate Strategy for WHO Secretariat. Report by the Director-General', EB105/3, 10 December 1999, http://apps.who.int/gb/archive/pdf_files/EB105/ee3.pdf.

## What was achieved?

While Brundtland's focus was on how to make WHO work better by defining its role, increasing cohesion between its different levels and, in particular, focusing on evidence-based policy, it is generally agreed that her greatest achievements were in enhancing WHO's status in the outside world, in helping to make health an integral part of the development agenda, and in stimulating and facilitating the development of new partnerships and funding.

Brundtland used her status and contacts as a former prime minister to promote more productive cooperation between WHO and its major counterparts in the health field in the UN, in the multilateral banks and the IMF, and in civil society and the private sector. She brought in academics and economists from Harvard and the World Bank, particularly to staff the new Evidence for Information and Policy cluster in WHO and thus provided the organization with the intellectual weight to conduct dialogues with others such as the World Bank and IMF. As noted above, she was much influenced by the Bank's 1993 World Development Report ('Investing in Health') with its emphasis on measuring the burden of disease with Disability Adjusted Life Years (DALYs) and the relative cost-effectiveness of different interventions. She brought economics (and politics) to the heart of WHO strategy. In that vein she appointed Jeffrey Sachs to head a Commission on Macroeconomics and Health, which sought to demonstrate that health was a good investment in promoting economic growth, which he later described as 'science-based politics'.[59] More than anything else, Brundtland helped to mainstream health as a key component of the international development agenda, which was manifested in several ways:

- The increasing focus of the G8 on health beginning in Okinawa in 2000;
- The health-related Millennium Development Goals;
- The rapid rise in development assistance for health, which began in about 2000.

Similarly, Brundtland and WHO played a varying role in the development of new partnerships.[60] These included:

- The 'internal' partnerships hosted by WHO e.g. Roll Back Malaria founded in 1998, Stop TB in 1998.
- The 'external' partnerships e.g. Medicines for Malaria Venture (MMV) in 1999, Global Alliance for TB Drug Development (now TB Alliance) in 2000.
- Global Alliance for Vaccines and Immunisation (now GAVI Alliance) in 2000. A major role in its establishment was played by the World Bank and the Bill & Melinda Gates Foundation but its first executive secretary was Tore Godal, special adviser to Brundtland in 1998–99, and Brundtland was its first chair.
- The Global Fund to Fight AIDS, Tuberculosis and Malaria. WHO launched a campaign called Massive Effort in 2000 to scale up interventions to tackle these three diseases but soon decided this ambitious advocacy on its part was not appropriate or helpful to the wider effort.[61] Nevertheless WHO, along with many others, played an important role in advocacy for the Global Fund and in bringing about its establishment.

Another of Brundtland's principal achievements was the Framework Convention on Tobacco Control (the first and only treaty so far negotiated under Article 19 of WHO constitution), which was adopted by the World Health Assembly in May 2003.

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59 Clift, C., 'The Commission on Macroeconomics and Health: Ten Years On', Meeting Summary, Centre on Global Health Security, Chatham House, January 2012, http://www.chathamhouse.org/sites/default/files/public/Research/Global%20Health/0112summary.pdf.

60 Again Jon Lidén's paper provides much historical detail on Brundtland's and WHO's role in the development of partnership initiatives.

61 Brundtland, G.H., 'Speech by Director-General. Massive Effort Advocacy Meeting', Winterthur, 3 October 2000, http://www.who.int/director-general/speeches/2000/english/20001003_massive_effort.html.

## What went less well?

The main deficiencies noted by observers relate to what was attempted internally – the One WHO agenda and the management reforms.

The new senior hierarchy of EDs and collective management only worked to a limited extent. Some of the initial ED appointments proved to be mistakes – there was a rapid turnover of EDs and by 2002 only one of the original group remained. In 2000, two of Brundtland's most trusted advisers, Jonas Støre (the head of her office) and Julio Frenk (ED for Evidence and Information for Policy) were called back to their countries to political posts. Nor did the collective model, in spite of her efforts to promote dialogue and communication, really succeed in breaking down the deep-seated competitive pressures for external funds built into the incentive structure at WHO as a result of the shortage of regular budget resources and the competition to secure extrabudgetary funds from donors. Perhaps inevitably, but also reflecting Brundtland's management style, existing WHO staff were alienated by the implicit vote of no confidence represented by the wholesale replacement of senior staff and the influx of new people with no background in the organization and a perceived different mindset associated with World Bank policies. Only two of the initial ED group were WHO insiders. Similarly, the consolidation of departments from 50 to 35 inevitably created a significant set of 'losers' who formed a disgruntled element within the organization.

The experiment of closer involvement and alignment of the regional offices with headquarters – the centrepiece of 'One WHO' – had very mixed results. The regional directors, while benefiting to some extent from WHO's much improved external reputation, felt that Brundtland, or some of her senior staff, were a threat to their status as elected heads of the regional offices. The unique regional structure of WHO, often claimed as its greatest asset, also proved to be its Achilles' heel since significant reform was politically very difficult, if not impossible.

In addition Brundtland, while successful in attracting additional EBFs to WHO, failed to make a significant impact on the growing imbalance between stagnant or falling (in real terms) regular budgetary funding and earmarked funding from donors. She also failed to instigate mechanisms where voluntary contributions were seen as a part of the organization's strategic priorities. Indeed it is precisely this issue that was the trigger for the current reform effort in WHO, as described below.

**The experiment of closer involvement and alignment of the regional offices with headquarters – the centrepiece of 'One WHO' – had very mixed results**

While Brundtland's efforts to build relationships with the wider group of international institutions involved in health, and to help foster new partnerships were largely successful, her initiatives to build bridges with the private sector, i.e. the brand-name pharmaceutical industry (by means of regular roundtables) were less successful (and her initial appointment of an ED from the pharmaceutical industry ended in an early exit). The existing staff in WHO dealing with pharmaceuticals regarded her efforts as too biased towards the brand-name industry, neglecting the potential for WHO to promote affordable access to medicines by opening up opportunities for the generic industry (an area where WHO did in fact play a significant role, starting in Brundtland's era). Of course, in the view of several member states, her approach was right and that of the staff wrong.

Perhaps as a corollary, Brundtland's attempts to reach out to the private sector coloured her relations with NGOs that were, in any case, deeply suspicious of private-sector motives in collaborating with WHO. Thus, rather anticipating arguments later used to criticize the proposal

for a World Health Forum in 2011, NGOs reacted against her overtures for closer relations with the private sector.[62]

Another highly publicized controversy was stirred by the attempt in the 2000 *World Health Report*[63] to compare and rank the performance of national health systems, which alienated a number of member states, in particular Brazil. This led to prolonged debate within and outside WHO. The issues raised were methodological (the report used a very large number of estimated data points whose rationale was not adequately explained or justified) and also concerned WHO's role in the sensitive area of assessing the performance of national health systems. The episode was unfortunate in that it called into question the credibility of one of the central tenets of Brundtland's reforms – WHO's commitment to evidence-based policy – but had a positive side in stimulating activity in the organization and at national level to improve the availability of data and in stimulating constructive debate on health-system performance. In a rejoinder to a late attack on the report's methodology by its editor-in-chief,[64] the director-general and her colleagues fiercely defended the overall positive impact of WHO's work in this area,[65] as did, ten years later, the former ED in charge at the time of the report.[66]

Finally, although the development of partnerships was regarded by many as positive, the relationship between WHO-hosted partnerships and WHO itself remains to this day a contentious issue. The governance of partnerships (which may be determined by funders and usually includes stakeholders) is often divorced from the governance structures of WHO itself. Each partnership is structured rather differently, but the essential issue mirrors, or is virtually the same as, that concerning the governance of regular budget versus extrabudgetary funds.

An overall assessment of the potential impact of the Brundtland reforms is difficult, in particular because she unexpectedly decided not to stand for a second term at a time when many considered her job half-done. The positive features, such as GAVI and the Global Fund, to a large extent have proved sustainable, and have major achievements to their name despite, for instance, current problems being experienced by the Global Fund. The internal reforms have not really been sustained although there remains a legacy in terms of the cluster structure. DALYs have permanently entered the WHO lexicon, although the then head of Evidence and Information for Policy (and then ED) now carries out very similar analysis outside WHO, funded by the Bill & Melinda Gates Foundation.[67] ADGs have returned and management support functions have been recentralized. Senior headquarters staff are critical of the way in which the financing arrangements have changed such that most of the regular budget is channelled directly to the regional offices; these changes, together with moves towards de-earmarking of voluntary contributions have, in many departments, caused drastic reductions in funding levels on which they could previously rely. Only a few departments with access to funds that are still earmarked have escaped such budget cuts.

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62 See, for instance, http://www.haiweb.org/campaign/PPI/sponsorship.response.html.

63 World Health Organization, *World Health Report 2000: Health Systems: Improving Performance* (Geneva: WHO, 2000), http://www.who.int/whr/2000/en/whr00_en.pdf.

64 Musgrove, P., 'Judging Health Systems: Reflections on WHO's Methods', *The Lancet,* 361 (2003); 1817–20, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)13408-3/fulltext.

65 Brundtland, G .H. et al., 'WHO Assessment of Health Systems Performance', *The Lancet,* 361, (2003): 2155, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)13702-6/fulltext.

66 Frenk, J., 'The World Health Report 2000: Expanding the Horizon of Health System Performance', *Health Policy and Planning*, 25 (2010): 343–45, http://heapol.oxfordjournals.org/content/25/5/343.full.pdf.

67 The Institute of Health Metrics and Evaluation (IHME), http://www.healthmetricsandevaluation.org.

## 6. CURRENT WHO REFORM (2010 ONWARDS)

In January 2010 Director-General Margaret Chan convened an informal consultation with member states on the future financing of the World Health Organization. The meeting originated as a result of budget discussions at the World Health Assembly and the Executive Board in 2009. Two key issues arose: how to better align the priorities agreed by WHO's governing bodies with the available finance, and how to ensure greater predictability and stability of financing to promote more realistic planning and effective management. While the reason for the meeting was the financial crisis in WHO, it inevitably led to more fundamental discussions about its priorities and thus inexorably to an explicit airing of the need for reform. According to the official report there was general agreement that WHO's normative work, surveillance, and response to epidemics and other public health emergencies were core work.[68] Several key issues emerged:

- To what extent, and how, should WHO address the broader social and economic determinants of health?
- What constitutes good partnership behaviour at the global and country levels – and what are the implications for WHO?
- What constitutes effective country support in countries at very different levels of development and capacity, and – recognizing that WHO needs to be of value to all member states – how can it match the support it provides more closely and flexibly to country needs?
- How can WHO be more consistent and effective in the field of technical collaboration?

Two sets of governance challenges were identified:

- How to deal with system-wide governance issues – acknowledging that the challenges facing WHO are far from unique – when each of the agencies involved in global health (in the UN and more widely) has its own individual governance structure.
- Recognizing the growing role of non-state actors, how to achieve more inclusive governance of global health.

The report said that

> *there was recognition that the current situation in which 80% of WHO's income relies on voluntary donor contributions, which are predominantly earmarked for specified purposes, is not sustainable. In the absence of change, greater alignment with agreed priorities will be unattainable. Participants agreed that improving performance is intimately linked to the way WHO is financed.*

The discussion was reported to have highlighted elements of a reform agenda for the organization:

- Tighter definition and alignment of core funding with priorities and core business.
- A more disciplined and coordinated approach to resource mobilization.
- Exploration of new processes for raising funds, identifying new donors and sources of finance.
- Better communication of WHO brand, impact and success.

The development of proposals for reform then proceeded through a number of consultations, from discussion at governance body meetings, a special meeting of the Executive Board in

68 World Health Organization, 'The Future of Financing for WHO: Report of an Informal Consultation Convened by the Director-General' (Geneva: WHO, 2010), http://www.who.int/dg/who_futurefinancing2010_en.pdf.

November 2011 and a member-states meeting in February 2012 on programmes and priority setting, to the presentation of a consolidated report to the WHA in May 2012.[69]

The reform proposals are grouped under three areas:

- Programmes and priority setting;
- Governance; and
- Management.

## Programmes and priority setting

As agreed at the February 2012 member-states meeting, the categories of WHO activities proposed for priority setting would be as follows:[70]

- **Communicable diseases:** reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria and neglected tropical diseases.
- **Noncommunicable diseases:** reducing the burden of noncommunicable diseases, including heart disease, cancer, lung disease, diabetes and mental disorders, as well as disability, and injuries, through health promotion and risk reduction, prevention, treatment and monitoring of noncommunicable diseases and their risk factors.
- **Promoting health through the life-course:** reducing morbidity and mortality and improving health during pregnancy, childbirth, the neonatal period, childhood and adolescence; improving sexual and reproductive health; and promoting active and healthy ageing, taking into account the need to address determinants of health and internationally agreed development goals, in particular the health-related Millennium Development Goals.
- **Health systems:** support the strengthening of health systems with a particular focus on achieving universal coverage, strengthening human resources for health, health information systems, facilitating transfer of technologies, promoting access to affordable, quality, safe and efficacious medical products, and promoting health services research.
- **Preparedness, surveillance and response:** surveillance and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters to contribute to health security.
- **Corporate services/enabling functions:** organizational leaderships and corporate services that are required to maintain the integrity and efficient functioning of WHO. [This was added by Secretariat after the meeting.]

The following criteria for programmes and priority setting in WHO were proposed:

- The current health situation including demographic and epidemiological trends and changes, urgent, emerging and neglected health issues; taking into account the burden of disease at the global, regional and/or country levels.
- Needs of individual countries for WHO support as articulated, where available, through the country cooperation strategy, as well as national health and development plans.

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69 'WHO Reform: Consolidated Report by the Director-General', A65/5, 25 April 2012, http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_5-en.pdf.

70 Draft Twelfth WHO General Programme of Work, http://www.who.int/about/resources_planning/draft_gpw_for_reg_commitees_2012_en.pdf.

- Internationally agreed instruments that involve or impact on health such as declarations and agreements, as well as resolutions, decisions and other documents adopted by WHO's governing bodies at the global and regional levels.
- The existence of evidence-based, cost-effective interventions and the potential for using knowledge, science and technology for improving health.
- The comparative advantage of WHO, including: (a) capacity to develop evidence in response to current and emerging health issues; (b) ability to contribute to capacity building; (c) capacity to respond to changing needs based on ongoing assessment of performance; (d) potential to work with other sectors, organizations and stakeholders to have a significant impact on health.

The Secretariat was asked to apply these criteria and categories, and WHO's core functions as defined in the Eleventh General Programme of Work (see Box 5), adjusted as necessary to address new realities, and incorporate the priorities so derived in the draft Twelfth General Programme of Work (GPW). The GPW would on that basis also define a limited set of high-level results and, in addition, more detailed priorities would be included in the budget for 2014–15.

**Box 5: Core functions of WHO**

1. **Providing leadership** on matters critical to health and engaging in partnerships where joint action is needed;
2. **Shaping the research agenda** and stimulating the generation, translation and dissemination of valuable knowledge;
3. **Setting norms and standards**, and promoting and monitoring their implementation;
4. **Articulating ethical and evidence-based policy options**;
5. **Providing technical support**, catalysing change, and building sustainable institutional capacity;
6. **Monitoring the health situation** and assessing health trends.

Source: Eleventh WHO General Programme of Work (2006–15), http://whqlibdoc.who.int/publications/2006/GPW_eng.pdf.

## Governance

Key reform components for the organization include:

*Improved scheduling of governing body meetings*

This proposed several options to improve the interaction between the EB and the Programme, Budget and Administration Committee (PBAC), and between them and the WHA and the Regional Committees. The WHA decided to keep the present schedule for the moment but asked for a study on the possibility of shifting WHO's financial year.

*Alignment*

To strengthen links between the EB and the Regional Committees and to ensure the latter have an input into global strategies, they would be asked to give their views on 'all global strategies, policies and legal instruments' as well as the GPW and programme budgets. To this end Regional Committee chairs would routinely report to the EB. The WHA concurred.

*Harmonization*

The procedures for nomination of regional directors should be revised in line with those for the director-general, reflecting the principles of fairness, transparency and an emphasis on the personal qualifications of the candidate. Selection criteria and an assessment process for candidates' qualifications should be established. The WHA broadly concurred.

*Strengthening the Programme Budget and Administration Committee (PBAC)*

The PBAC's mandate should be broadened from the managerial and administrative to include programmatic and performance matters. Proposed new terms of reference ask it to provide guidance to the EB on (a) programme planning, monitoring and evaluation and (b) financial and administrative issues. Its role in oversight of independent evaluation would also be strengthened.[71] The WHA agreed.

*Strategic decision-making in governing body meetings*

The EB should play a role in limiting the number of draft resolutions and other agenda items. Various means of doing so are proposed including applying criteria as in the GPW to review EB agenda items and more use of chairman's summaries rather than resolutions. The WHA broadly agreed.

*Effective engagement with other stakeholders*

The proposal made by the Secretariat for a World Health Forum to incorporate the private sector and civil society was rejected by member states on a number of grounds – mainly concerns about maintaining the paramountcy of member states and fears of some about giving the private sector a formal role in WHO deliberations. In the light of this, three streams of work are proposed: separate papers to be submitted to the EB on relationships with NGOs and the private sector, and a review of WHO's hosting arrangements and proposals for harmonizing work with hosted partnerships. The WHA agreed and also set out principles that should guide the director-general in developing these policies:

*(i) the intergovernmental nature of WHO's decision-making remains paramount;*

*(ii) the development of norms, standards, policies and strategies, which lies at the heart of WHO's work, must continue to be based on the systematic use of evidence and protected from influence by any form of vested interest;*

*(iii) the need for due consultation with all relevant parties keeping in mind the principles and guidelines laid down for WHO's interactions with Member States and other parties;*

*(iv) any new initiative must have clear benefits and add value in terms of enriching policy or increasing national capacity from a public health perspective;*

*(v) building on existing mechanisms should take precedence over creating new forums, meetings or structures, with a clear analysis provided of how any additional costs can lead to better outcomes.*[72]

## Management reform

*Effective technical and policy support to member states*

Stronger and more effective support to countries is seen as a key outcome of reform. This would require improvements to WHO's work at all levels, not just at country level, and would include its

71 'WHO Reform. Revised Terms of Reference for the Programme, Budget and Administration Committee of the Executive Board', EB131/10, 11 May 2012, http://apps.who.int/gb/ebwha/pdf_files/EB131/B131_10-en.pdf.

72 Decision WHA65(9), WHO Reform. May 2012, http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_DIV3-en.pdf.

normative work. Progress was being made in enhancing delegated authority to country offices. Addressing concerns expressed in several evaluations,

> *future developments will shift the focus to the leadership role of Heads of WHO Offices. In particular, enabling Heads of WHO Offices to play a more authoritative role in facilitating policy dialogue: across different parts of governments, with civil society and nongovernmental organizations, and with all other in-country health partners.*

Measures will include improving selection processes to get the best candidate for the job; developing an attractive career path and harmonizing with UN grading at country level; and intensive mandatory training for heads of WHO offices in leading policy dialogue and diplomatic and negotiation skills. In addition the different roles and responsibilities of the three levels in WHO are defined (see Box 6).

### Box 6: Roles and responsibilities at different levels in WHO

#### Country level

**Technical cooperation:** Lead the provision and brokering of technical cooperation with Member States through the development of a country cooperation strategy; and identify areas requiring technical support and institutional strengthening.

**Policy advice and dialogue:** Provide policy advice and lead policy dialogue at country level, as well as facilitating broader engagement of countries in regional and global policies and dialogues.

**Norms and standards:** Support countries to participate effectively in the development of global norms and standards, guidelines, tools and methodologies, and in adapting them for country use and implementation.

**Knowledge generation and sharing:** Support the collection, analysis, dissemination and use of national data (including surveillance data, country experiences and trends) required for monitoring the global health situation, and support research.

**Convening:** Convene and coordinate health actors in support of national health developments and in response to public health emergencies.

#### Regional level

**Technical cooperation:** Provide technical support for the development of country cooperation strategies and backup for institutional strengthening at country level; foster technical cooperation among countries; lead collaboration with Member States that have no WHO Office.

**Policy advice and dialogue:** Provide a platform for sharing policy advice, and contribute to the development of global policies and strategies, provide backup to WHO Offices on policy advice and dialogue; and advocate on regional health matters.

**Norms and standards:** Develop or adapt guidelines, methodologies and tools; adapt global strategies to the regional specificities.

**Knowledge generation and sharing**: Regional aggregation and validation, analysis, dissemination and use of health-related data (including surveillance data) and trend analysis; comparative analysis of and lessons learnt from regional country experiences, and sharing good practices on issues of region-wide concern.

**Convening:** Convene regional governing bodies and regional and inter-regional health platforms; facilitate Member States' engagement in regional initiatives and coordinate with regional and sub-regional entities.

**Enabling:** Provide backup on administrative and managerial issues for WHO Offices.

**Headquarters**

**Technical cooperation:** Provide backup for country offices on technical issues and support institutional strengthening at country level.

**Norms and standards:** Lead in the formulation of technical norms and standards; develop methodologies, tools and global strategies.

**Knowledge generation and sharing:** Global consolidation, dissemination and use of health related data (including surveillance data) and global trend analysis; research and innovation on issues of global significance; and broker inter-regional exchange of experience and lessons learnt.

**Convening:** Convene global governing bodies; convene key stakeholders for global health initiatives, and lead in shaping the health agenda at global level.

**Policy advice and dialogue:** Formulate global public health policies; coordinate strategic global public health goods, and advocate on global health matters.

**Enabling:** Develop policies, systems, and oversight and accountability frameworks for administrative and managerial issues.

Source: 'WHO Reform: Consolidated Report by the Director-General', A65/5, 25 April 2012, http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_5-en.pdf.

*Staffing that is matched to needs at all levels of the organization*

Strategies are set out to make improvements in the following areas:

- Staff development, learning and performance management;
- A more flexible workforce;
- A more mobile workforce.

*An approach to orient financing towards agreed priorities*

This will introduce resource allocation linked to results-based budgeting. The exact method is being worked on but will be based on a costing of deliverables at each level of the organization. This will be complemented by efforts to increase the predictability and flexibility of financing. Accurate prediction of income for each biennium was necessary, based on continuing dialogue with donors and agreement on priorities – which should be the sole responsibility of governments. In addition, the financing dialogue with state and non-state donors should be 'open to scrutiny by all Member States'. Flexibility may be improved if the new framework for priority setting can encourage earmarking at category level only. The WHA agreed that a paper developing these proposals be put to the EB.

*An organization that is accountable and effectively manages risk*

Strategies are set out to make improvements in the following areas:

- internal control framework;
- accountability framework;
- risk management;
- conflict of interest;
- transparency and disclosure policy.

There is also a proposal to establish a new Ethics Office to promote ethical standards across WHO, including a Code of Ethics, and to investigate alleged misconduct and violations of ethical standards.

*An established culture of evaluation*

An evaluation policy has been approved by the EB and an evaluation culture will be promoted within WHO. The first stage of an independent evaluation of the reform process has been completed by the External Auditor (India's Comptroller and Auditor General).[73] The specific modalities of the second-stage evaluation were considered at the January 2013 EB. In support of this, the Joint Inspection Unit has been asked to update its two earlier reports on WHO – the 1993 report on decentralization (quoted above) and a 2001 review of management and administration, which had proposed a series of administrative and financial reforms, notably casting doubt on the wisdom of pursuing the devolved Management Support Units strategy adopted under Brundtland.[74] These updated reports were also due to be discussed at the January 2013 Executive Board.[75]

*An organization that effectively communicates its contribution to and achievements in global health*

Various improvements are being made to improve communications, including centralization, development of an Emergency Communications Network and a system for measuring public and stakeholder perceptions and needs.

73 'WHO Reform. Independent Evaluation Report: Stage One', A65/5 Add. 2, 18 May 2012, http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_5Add2-en.pdf.

74 'Review of Management and Administration in the World Health Organization', EB109/30, 17 December 2001, http://apps.who.int/gb/archive/pdf_files/EB109/eeb10930.pdf.

75 'Review of Management, Administration and Decentralization in the World Health Organization, Report of the Joint inspection Unit', EB132/5 Add.6, 4 January 2013.

## 7. CONCLUSION

The above discussion of the World Health Organization's evolution and efforts to reform it covers a very wide range of topics concerning governance, structure, policies, priorities, financing and management. The intention was to provide background and historical perspective relevant to current discussions of WHO reform.

As described above, the current reform process within WHO is in many ways admirably comprehensive but for understandable reasons there are various potential avenues for reform that are not fully addressed. It is also apparent that several issues, particularly of a structural and constitutional nature, that were identified in previous reform attempts or assessments of the organization but were never acted on or fully taken up, are not well covered in the current reform process. The current process does not ask fundamental questions about WHO's place in the international system as it has now evolved, nor whether WHO's governance, management and financing structures need more fundamental change than is currently envisaged. It is therefore unclear whether the latest reform efforts will be sufficient to enable the organization to fulfil its potential.

## ABOUT THE SERIES

An earlier version of this paper was written as a background paper prepared for the first meeting of the Global Health Working Group on 'WHO and the International System' in October 2012. It is part of a Chatham House publication series related to the Centre on Global Health Security Working Groups, which are aimed at improving global health security. The first two Working Groups address issues of governance and financing.

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