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Bettina Borisch, Federation's Pages Editor

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WHO reform: A personal perspective

Money Talks

The world needs global norms, rules, and standards in health more than ever before – yet the organization mandated to lead and coordinate global health work has an overall budget equal to that of the Geneva Cantonal Hospital. How can this be explained? Let us compare and calculate: the global health industry is estimated at a volume of US 6.5 trillion dollar; the global economic loss from Severe Acute Respiratory Syndrome (SARS) was close to 40 billion dollar; China's 5-year plan to invest in rebuilding the rural medical service system cost 20 billion RMB (2.4 billion dollar); the United States spends 802 billion dollar yearly on Medicare and Medicaid alone and about 18 per cent of its GNP on health; the Global Fund for AIDS, Tuberculosis, and Malaria in 2012 approved funding of 22.9 billion dollar and the Bill and Melinda Gates Foundation (BMGF) alone gives approximately 800 million dollar a year for global health. The annual World Health Organization (WHO) budget is now roughly two billion dollar – miniscule in relation to the industries and the states it is supposed to provide with global public goods – rules and regulations – and minuscule in relation to the health development donors who are particularly attracted to disease- and 'result'-based global health initiatives and organizations.

Why is this so? First and foremost – despite a new political commitment to the organization – the member states still cannot quite agree on what kind of organization they want. The tension is still tangible between a role for the

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WHO as a normative organization and a guarantor of health security that serves all member states equally versus one as a development actor that should be giving priority to the diseases of poverty – even though this need not be a contradiction. The fear of some countries of losing sovereignty as well as some of the WHO funding at country level is palpable. Power has shifted: currently, no new health agreement can be reached without the will and interest of the BRICS (an association of emerging national economies: Brazil, Russia, India, China, and South Africa) and the MICS (middle-income countries) – and neither group is quite sure yet how to approach their global roles and responsibilities within the multilateral organizations (note the stalling of negotiations in an accepted rule setting organization, the World Trade Organization).

What is Leadership – Global Initiatives or Global Public Goods?

How did we get here? Lack of effectiveness, inefficiency, lack of leadership – that was the favorite gripe about the WHO in the last 20 years. This follows WHO's failure with historically new challenges that emerged with the HIV/AIDS epidemic. We saw creation of new organizations reinforced by the venture philanthropy of the BMGF. 'New' and 'old' forms of governance were juxtaposed to imply that 'the new' was more effective and was going to replace the state-based international organizations. The global health community was enthralled by the rapid increase in funds, organizations, and jobs: aggregate resources flowing to global health rose from 7 billion dollar in 2000 to 27 billion dollar per year in 2009. The 'Health Millennium Development Goals' (MDGs) exacerbated the strategic and financial imbalance: to reach the MDGs, effort focused on adding funds for immunization and HIV/AIDS, tuberculosis, and malaria initiatives, and provided opportunities for positioning countries and heads of state. A simplistic conclusion resulted: because WHO's budget amounted to only a miniscule part of this money, WHO must be declining in relevance.

But what initially seemed a zero-sum game has not come to that. In the new century, while still being described as weak and ineffective, WHO actually:

- embarked on a number of key rule-setting initiatives (International Health Regulations (IHR) 2003; Framework Convention on Tobacco Control (FCTC) 2005; Pandemic Influenza Preparedness Framework (PIP/2011);
- provided clear guidance for the financing of health systems (World Health Report 2011);
- responded to major disease outbreaks and externalities (SARS 2003, H1N1 2009/2010); and

- launched new value-driven initiatives such as the Report of the Commission on Social Determinants of Health 2008.

In addition, WHO has been testing and practicing a new stewardship function as a global health governance network hub. In most of the meetings of the governing bodies, and in many of the key negotiations and events, more global health stakeholders became involved in a myriad of ways, for example, in the negotiations leading to the UN political declaration on non-communicable diseases (NCDs) 2011.

Rule setting is a global public good that can take many forms and usually does not grab the headlines. It requires grueling day-to-day work that many global health actors eschew as overly bureaucratic or downright boring. The same applies for the negotiation of such rules – this can be immensely tedious. One member state complained recently that WHO had too many lawyers – I wish that were so! Rule setting includes the work on classifications (such as classification of diseases or the WHO model list of essential medicines). Rule setting does not need to be financed exclusively by the WHO regular budget. A recent OXFAM analysis shows that only 10 per cent of the costs of the Expert Committee on Specifications for Pharmaceutical Preparations, which underpins all quality assurance guidance for the development, production, quality control, regulation, inspection, and distribution of medical products worldwide, are financed by WHO. But WHO needs a clear and transparent financing model to allow (or indeed require) all those who benefit to contribute to the financing of such a global public good.

Reform for What?

There has been so much talk and paper on the WHO reform^{1,2} that it is difficult to see the wood for the trees. Of course, the organization must get better in terms of governance and management – so too must many national ministries of health. But what lies at the core? *In my view, the WHO must focus on global public policies to address underprovision of global public goods for health, and in conjunction its member states must practice smart sovereignty* (see definition below).

The IHR and the FCTC are often mentioned as instruments that only WHO, as a multilateral and intergovernmental organization, could deliver. They can be considered – as are other global agreements and treaties – as global public goods for health. This means that they *pertain to things and conditions that transcend national borders and often affect many, if not all countries. Moreover, some of these challenges are even likely to spread their costs and benefits across several generations, past, current and future.*³ They require rules that apply across borders, and institutions at all levels of governance to

supervise and enforce these rules. Recent deliberations on the global response to NCDs clearly reflect the need for such an approach; action is needed across national boundaries, and across sectors to address commercial determinants of health. But global public goods can only be achieved if countries agree to pool their efforts because they benefit as nations and as a global community. Such an approach, combining national and global interests, has been termed ‘smart sovereignty’ – the added and unique value of the WHO at the beginning of the twenty-first century lies in helping countries exercise their policymaking sovereignty more effectively and intelligently *for the benefit of all*. I believe that governance should be the focus of the WHO reform. Global rule setting cannot be subject to charity funding.

And Back to the Money ...

Today, 23 per cent of the WHO’s budget comes from the regular assessed contributions to the organization by member states. The issue is not ‘good’ or ‘bad’ money – it is priorities. Money talks – and too frequently the priorities set by the 193 Ministries of Health have been bypassed by the development agencies that hold the purse strings. Therefore, many of the countries (and the European Union (EU)), the leaders of which do see a need to support the core rule-setting functions of the organization, are providing un-earmarked voluntary contributions. Despite the increase of global health challenges (the most recent outbreak of H7N9 is a case in point), there seems to be a general agreement that an increase of regular assessed contributions would not pass national parliaments.

In my view, the new type of budget and the financing dialogue proposed as part of the WHO reform can be a first step to establish a new financing model for the WHO. It can be an entry point to a discussion on what value we attach to global public goods for health – such as norms and rules, health security, rapid outbreak response, polio eradication. What level of funding does this require? Who contributes? The EU and the G8 leaders should take this challenge to the G20 and the UN General Assembly as part of the debate on the sustainable development goals, maybe linked to the global financial transaction tax. The debate on financing global public goods for health must be conducted beyond the WHA.

Where does the WFPHA come in? The WHO reform process has led to an intensive involvement of civil society networks. They have contributed significantly to the debate on the role of WHO in global governance and other issues that lie at the core of the WHO’s independence. I suggest that WHO’s role in the provision of global public goods, smart sovereignty by member states willing to pool responsibilities, and new financing mechanisms for

global public goods for health become the three focal issues that civil society prioritizes in the context of WHO reform. And because 'good global health begins at home', much of this advocacy needs to take place within countries, not only at the global level.

Declaration of interest: Ilona Kickbusch is the director of the Global Health Programme at the Graduate Institute in Geneva. She was a WHO staff member between 1981 and 1998. Presently, she advises several WHO programmes. The Global Health Programme is involved in Global Health Diplomacy training with several parts of the organization. She has been an advocate of a global public goods approach to global health for many years.

Ilona Kickbusch
Adjunct Professor, The Graduate Institute Geneva

References and Notes

1. WHO website on reform: http://www.who.int/about/who_reform/en/.
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3. Inge, K. (2013) Global Public Goods: A concept for framing the post-2015 agenda. Discussion Paper, Deutsches Institut für Entwicklungspolitik, Bonn, [http://www.die-gdi.de/CMS-Homepage/openwebcms3_e.nsf/%28ynDK_contentByKey%29/ANES-959D4N/\\$FILE/DP%202.2013.pdf](http://www.die-gdi.de/CMS-Homepage/openwebcms3_e.nsf/%28ynDK_contentByKey%29/ANES-959D4N/$FILE/DP%202.2013.pdf).