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WHO: Past, Present and Future

Democratizing the World Health Organization

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ABSTRACT

A progressive erosion of the democratic space appears as one of the emerging challenges in global health today. Such delimitation of the political interplay has a particularly evident impact on the unique public interest function of the World Health Organization (WHO). This paper aims to identify some obstacles for a truly democratic functioning of the UN specialized agency for health. The development of civil society's engagement with the WHO, including in the current reform proposals, is described. The paper also analyses how today's financing of the WHO – primarily through *multi-bi* financing mechanisms – risks to choke the agency's role in global health. Democratizing the public debate on global health, and therefore the role of the WHO, requires a debate on its future role and engagement at the country level. This desirable process can only be linked to national debates on public health, and the re-definition of health as a primary political and societal concern.

Introduction

This article focuses on the need for democratizing the World Health Organization (WHO) and the public dialogue around health. Is the WHO functioning democratically today? First of all, this question requires some clarifications on how democratic legitimacy is actually defined in relation to WHO's functioning.[1] Secondly, we have to separate the democratic functioning of the WHO itself, from the current functioning of the global governance for health in which the WHO has a substantive role. This article mainly focuses on the first issue, and will only touch upon the latter.

Authors have diagnosed 'a deficit of democracy' as one of the key challenges for the WHO, as well as for the wider governance of global health.[2] It is one of the reasons that WHO's work on human rights and health equity has been hampered over the last decades.[3] What has changed in recent times, in line with global trends in other sectors, is the mounting concentration of power – and money – when it comes to the bare handful of key decision-makers in global health. While WHO is still functioning as a member state driven multilateral organization, it is subject to a trend in which global governance has become polycentric and states have lost authority.[4] Is it then possible for the WHO to regain its multilateral legitimacy, through enhancing the quality of its democratic interplay in decision making? Can the WHO really be *the* key health authority in a globalized world based on a *cosmopolitan democracy*? And what would be the incremental steps required for this?[5]

The democratic legitimacy of the WHO

Democratic legitimacy in transnational governance arrangements can be conceived as a five-faced prism, whose surfaces are respectively: (1) representation; (2) accountability; (3) transparency; (4) effectiveness; and (5) deliberation.[1] Before

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we address these different faces, a fundamental contradiction in contemporary multilateralism requires explanation.

The WHO, like other UN institutions, has been created to enhance cooperation between states on issues of security and welfare (e.g. Polio eradication). As this cooperation is more effective than action by states alone, this creates *output legitimacy*. This should be complemented by *input legitimacy*, which implies the diversity of representation and inclusiveness of all its (sovereign) member states.

For example, an international convention, such as the Framework Convention of Tobacco Control (FTCT), is so powerful because it is a diplomatic negotiation between 194 member states *and* because it has included deliberation with non-state actors such as civil society.[6] This ideal vision of democracy is tarnished by a contradiction between the nominal state-egalitarianism of multilateral organizations and the realities of power politics, where weaker states may be unwilling to defy their powerful neighbours, creditors and trade partners. Moreover, many countries in the UN system are undemocratic or only partial democratic and their positions in the UN do not necessarily represent the interests of its citizens. Multilateral organizations are not organized democratically – with equal votes for each individual – but on a statist basis.

Principles of state sovereignty, whose origins lie in monarchy, and democratic policy making are conflicting. Within the 21st century, the ideology of democratic governance makes it harder to organize the world on the basis of sovereign states. In democratic theory, individuals, not states are the subjects of political and moral concern.[7] There is hence a demand for UN institutions to adjust their governance models by improving its input legitimacy that goes beyond state representation. This could imply the inclusion of 'extended state' representatives, that in the views of Antonio Gramsci includes not only the political sphere but also exists of, and is closely linked with civil society. Both *within* states and *within* multilateral organizations, this 'extended state' can contribute to the democratic legitimacy of policies.[8]

Representation (inclusiveness)

The WHO remains in today's globalized world the one 'directing and coordinating authority' for the realization of the right to health and universal coverage: A role that is tightly embedded in its Constitution.[9] WHO member states have a legal responsibility for the health of their citizens. Currently, the WHO consists of 194 member states. This includes tiny states such as Monaco as well as a giant country like China.

Over the recent years, WHO's formal governance bodies, the World Health Assembly (WHA) and Executive Board (EB), have become more transparent and accessible, both for member states and non-state actors.[10] One of the positive effects of the current WHO reform is that countries become better prepared to the meetings. Diplomatic cooperation between member states has become more intense. For example, since the European Union (EU) has a formal foreign diplomatic service (2010), it also has a formal delegation to the WHO.* The EU delegate facilitates the EU 28 members to come to a joint position on WHO policies.[11] As a result, other regional economic integration bodies, such as the Union of South American Nations (UNASUR) and the African Union (AU) also internally consolidate their positions on WHOs policy. There is a growing interest in the role of the 'BRICS' (the emerging economies Brazil, Russia, India, China, South Africa) in global health and the WHO. The two BRICS health ministers meetings so far have identified shared global health priorities such as non-communicable diseases (NCDs) and cooperation for Research and Development. Despite robust interventions of India and Brazil at the WHA, the BRICS have not yet spoken out en bloc at the WHA or EB, and rather focus their diplomatic efforts on the G20.[12] Countries start to take the WHO and global health more serious within their foreign policies and have created dialogue and space with its domestic stakeholders to prepare its position for the WHA and EB.[13]

However, engagement by member states in WHOs policies and its governance structures remains limited in general. WHOs governance system is considered archaic, while the policies of the organization, including appointments of strategic positions, are politicized and determined by its main donors.[14] At the WHA in 2013 it has been noted by some member states that 'governance has been the most neglected area of the reform process', especially when it comes to WHOs relationship with external actors.[15]

Inadequate finances and a lack of transparency and accountability

Looking back at the WHO history, one realizes that member states have not always done the agency a very good service. For example in 1984, in response to the perceived politicization of the UN organizations in the late '70s, the so called Geneva group (comprising the 11 major donors of the UN agencies, including the US and several European states) set out to restrict the growth of international agency budgets, including the WHO, to zero in real terms.[16] In the case of the WHO, this policy was further sharpened to nominal zero growth in 1993.

De facto, just as the Health for All policy was to be enacted after the Alma Ata declaration in 1978, the agency started to be choked and bereft of its financial capacity and potential development. Today, this deprivation has become a structural condition, and WHO has lost control over its budget, hence over its institutional autonomy. The vast majority of the funding to the agency is provided via extra-budgetary voluntary contributions that – through the WHO – actually serves the interests of particular state and non-state donors. The OECD has phrased this development *multi-bi financing*.[17] Through this increasing trend, participating governments and others are controlling international agencies more tightly, thereby impacting on their policy priorities.[18] In its WHO-strategy 2011–2015, Sweden argues that the WHO's legitimacy is undermined by accountability issues regarding the allocation of resources. Budget control was found to be weak and operations only partly governed by decisions of the WHA and EB.[19]

Funding for global health has grown significantly over the past decade, from US$ 5.7 billion in 1990 to US$ 27.73 billion in 2011.[20] This money has largely bypassed the WHO, possibly

* The EU has an observer status at the WHO. It speaks with 'one diplomatic voice' during the EB and WHA via its half-year rotating member state presidency.

because of donors' lack of confidence in the agency.[21] The current trends demonstrate that most funding has shifted to development assistance for global health. WHOs core public health policies and norm-setting role risks to remain underfunded.

Effectiveness (decisiveness)

The role of the WHO at the national level is often weak, for different reasons. The focus of WHO's activities in countries is primarily technical support to governments. Evaluation of programs is weak, resulting in a lack of insight if resources are spent effectively and efficiently. For member states, which use taxpayers' money to fund the organization, this is hardly satisfactory, and therefore they demand a greater degree of transparency and accountability during the ongoing effort to reform the WHO.[22]

WHO's effectiveness is inherently hampered by the fact that its official guidance is derived from 194 Members. Resolutions and treaties by the WHA and EB emerge in general by consensus, not by voting.[†] This 'soft diplomacy' has resulted that both the International Health Regulations and the FCTC, the two legally binding WHO agreements, do not include dispute settlements. Its language promotes and urges active cooperation between states and the WHO, without possibilities for external enforcement of public health measures.[23]

Furthermore, WHO predecessors have been Regional Sanitary Offices, and this regional structure has been maintained when WHO was founded in 1946. The six regional offices of the WHO have their own governance structures (regional committees). Coordination and coherence between WHO headquarters and the regional offices have been a matter of concern, with fundraising and allocation not always connected to global strategic objectives. A case can be made for strong regional and country offices, if only to be able to provide context-specific support. Needs in the African region are obviously very different from needs in other regions and priorities of work will differ. The current regional structure, with its different levels of management and performance, can be considered a key impediment to its effectiveness.[24]

Deliberation (epistemic reliability): civil society interaction with the WHO

The relation between the WHO, civil society organizations' (CSOs) and other non-state actors is controversial. In the WHO constitution, cooperation with non-state organizations and individuals is spelled out in several articles (art. 2, 18, 71).[25] Over the first decades, NGOs cooperated with the WHO mainly in the execution of programs and via professional consultations. Current principles governing the relations between WHO and NGOs were agreed upon in 1987.[26]

In the 1990s, the wave of reform aspirations within the UN system prodded the recognition that solutions to overcome development, poverty and human rights issues could not be addressed by member states alone. 'The universalization of Western liberal democracy as the final form of human government' – as described in Francis Fukuyama's *The End of History*[27] – became the contagiously dominant vocation. Firstly, it led the UN to look for a more active donor-driven embrace with the private sector as the new paradigm for development. The result is the 'critical platform' of the UN Global compact. Former director Brundtland was instrumental in re-engineering the way of working of the WHO along the lines of the Global Compact. The new global business model of multistakeholder cooperation she strongly pushed, kicked off the mushrooming of public private partnerships in health, vertically directed at controlling a few diseases such as HIV/AIDS, tuberculosis and malaria.[16]

Secondly, Brundtland tried hard to put health on the world stage and secure a role for WHO in the definition of the new development agenda underpinned by the values of equity, human dignity and human rights. A key component of this vision was the achievement of the FCTC, in which NGOs have played an unprecedented role in their collaboration with the WHO Secretariat against the aggressive strategies of the tobacco industry. The process allowed NGOs gain importance in the diplomatic policy deliberations on global health issues, with a very strong and competent monitoring role that continues today.[6]

In 1997, a meeting between WHO and 130 NGOs delivered promising recommendations aimed at strengthening the collaboration between NGOs and WHO at local and national level. Considering NGOs as vital allies, WHOs Health for All strategy even suggested that WHO should appoint a formal NGO representative to the EB and the WHA.[28] WHO did consecutively establish a partnership department, which developed the Civil Society Initiative (CSI). A new policy proposal for the interaction between the WHO and NGOs, building on the work of the CSI, was tabled in 2004 at the 57th WHA.[29] The painstaking process was put on halt by a bare handful of countries (including China). Consideration of a new civil society policy has been halted since then.

Financing: the core of the WHO reform

The WHO, through its Director General Margaret Chan, initiated a new process of reform in 2010. The need for predictability and sustainability of financing is at the core of the organization's reform initiative.[30] 75% of WHO's programs in 2010–2011 were funded through extra-budgetary voluntary contributions, 91% of which were earmarked for specific donor-driven priorities and programs. Uncontrolled donor dependence has directed the organization towards vertical programs for disease control relying mostly on drug donations. Funding for health systems has been systematically ignored. 18% of the donor funding comes from private foundations: the Bill and Melinda Gates Foundation (BMGF) is the second biggest funder of the WHO after the United States.[‡] The vast majority of the BMGF's funding is channelled to the roll out of existing vaccines and the research and development of new vaccines in low- and middle-income countries, mostly developed and produced by large pharmaceutical

[†] It is noted that sometimes consensus not emerges between states, as in the case of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property in 2008.

[‡] The BMGF donated US $446 million in the period 2010/2011.

companies in the United States and Europe.[31] A new mechanism in the form of a *financing dialogue* was proposed to the EB in January 2013.[§] The financing dialogue is marketed as an innovative and transparent approach to secure the required funds.[32] CSOs have expressed a shared concern that this approach may further institutionalize WHO's donor dependence.

WHOs governance with external partners

There is general agreement within the WHO Secretariat and with several governments that NGOs do bring a moral and qualitative strength to global health negotiations. Their role does help to promote more transparency and accountability in the different health negotiations, with healthier decision-making as a result.[26]

Within the framework of the reform process, in 2011 the WHO Secretariat, taking the input of Brazil, suggested to convene a World Health Forum (WHF) as 'to increase engagement and trust in the international health system'. The WHF was to have the 'role of identifying from the different perspectives of its participants, future priorities in global health'.[33] Reassurance was given that the proposed mechanism would not 'usurp the decision-making prerogatives of WHO's own governance'. Although NGOs broadly support inclusive consultation mechanisms on global health issues, their reaction against the WHF came as a surprise to many member states, and to the Secretariat. Their strongest criticism was the notion of setting up institutional practices at the WHO for increasingly participation of not-for-profit as well as commercial actors, while a robust mechanism to address conflict of interest lacking.[34] In the end the WHF proposal was dropped by member states.

Since 2011 several attempts have been carried out by NGOs to improve the negotiating dynamic for the WHO reform and raise key issues to give the reform a constitutional sense of direction.[35] The Democratizing Global Health Coalition, a group of public interested oriented NGOs, stresses to regulate WHO's engagement with external stakeholders, including NGOs itself. It advocates for clear regulations to be set in place to protect the WHO from undue private sector influence through the development of a comprehensive conflicts of interest policy.[36] Until now, such a policy has not yet been seriously addressed by the reform initiative.

WHO and governance for global health

The major responsibility for the future of the WHO lays with its member states. While much lip service is paid to the need for capitalizing more effectively on WHO's leadership position in global health, up to now the reform process has determinedly avoided a serious discussion on the WHO's role in global health governance.[37] The related documents at the 132nd and 133rd EB were left aside without any discussion.[38,39] In the wake of the global alert concerning NCDs, the WHO is expected to take a more active role in regulating key issues bearing an impact on health, including alcoholic beverages, food safety and nutrition. The agency has tried already to address a number of challenges related to its role in a globalized economy. The trade and health agenda is a well-known case in point, with its controversial intellectual property chapter. The same can be said about the social determinants of health, climate change and human rights.[40] It has been argued that a fundamental review and strengthening of the global governance system for health is required to address 21st century health challenges. There is a distinct lack of overall leadership among all global institutions affecting health. This review and restructuring has to take place outside existing structures, in this case WHOs EB and WHA, in a purpose specific forum akin to the Bretton wood conference from 1944 that established the key multilateral institutions, but with far greater transparency and inclusiveness.[41] Others argue that WHOs constitution needs to be revised, which 'could be used to fill gaps in global governance, hopefully in ways far more revolutionary then the meek evolutionary changes to the agency currently being discussed as part of WHOs reform'.[42]

Democratizing the WHO: ways forward

Regarding globalization, there is dispute in political science between *realists*, *complex multilateralists* and *cosmopolitan democrats*. Realists argue that national political power and associated international agreements will continue for the foreseeable future, while complex multilateralists suggests that global social movements do already influence international organizations and bypass the national policy making process but that national policies are *also* important. Cosmopolitan democrats view the world moving towards a new situation within which supra-national forms of accountable global governance are being constructed.[43] Seen the historic supra-national developments within the EU, this form of 'regionalization' might also happen in other parts of the world.[5] Contemporary multilateral institutions such as the WHO should begin to reconstruct their legitimacy on a 21st century basis, with more emphasis on democratic principles and less on national sovereignty. The right approach for WHO is likely one of complex multilateralism, as in the contemporary world global democracy is unfeasible, but it would be wrong to close off the possibility of a democratic governance mechanism eventually developing on a global level.[7]

What does this imply for WHO? In the WHO reform process, *output legitimacy* has already been addressed in the form of stronger internal governance procedures, improvements in management and organizational efficiency, and a results-oriented 12th general program of work, complemented by a bi-annual budget and outcome indicators for monitoring.[44]

Concluding from the analysis on its democratic practices, there is still an absolute need to enhance WHO's *input legitimacy* via its representation-, financing- and deliberation policies. As the WHO is a member state organization, discussion over its future role should be done at the country level. Diffusion of governance levels for health at state level is

[§] i.e. a venue where member states and non-state donors come together after approval of the 12th General Program of Work and associated 2-years budget (a combination of Assessed contributions and Voluntary Contributions).

becoming more complex. There is hence the need for inclusive and institutionalized cross-sectoral policy fora at the national level to shape WHO policies (and wider global health issues).[45] It will prepare and enhance legitimacy of the country delegation to the WHO. Moreover, it will help to bring WHOs role to the attention of the health community and public, and more into the political debate. Countries like Norway and Thailand already have such mechanisms.[46,47] However, in current times many countries in Western Europe are privatizing their health services and downsizing their public sector in the wake of the financial crises and related austerity measures. Recent developments indicate a *decrease* of multi-bi financing for global health that could lead to *less* and not to *more* engagement by member states in the WHO.[48] The debate on WHO and global health can hence not be isolated from national public health programs that face serious budget cuts.

Regarding WHO engagement with CSOs, there is a desire to re-initiate the policy developed under the Civil Society Initiative and proposed to the 57th WHA.[29] This policy proposes clear principles for accreditation and collaboration with NGOs. Some non-state actors reflect mainly the interests of stakeholders from corporate entities and instrumentalize the WHO and its role in health as to fit with its own social responsibility image. A good example is the profile of the BMGF as the major philanthropist in global health, while at the same time the foundation is the major shareholder of Coca-Cola, a beverage whose contributions to health are doubtful.[49] Transparency and accountability are needed. WHO cannot afford a blurred policy of collaboration with non-state actors; values, principles, inclusion and exclusion criteria that benefit public health outcomes have to be spelled out with conviction. WHO could learn from the Food and Agricultural Organization, whose Strategy for Partnerships with CSO could serve as an example, and which includes also community organizations and social movements.[50]

The financing of the WHO remains the most salient point of the reform. WHO does not necessarily require more funding in absolute terms – Its US$4 Billion bi-annual budget for 2014–2015 should be sufficient to fulfil its mandate – but it does require core funds and predictable sources for financing its key functions. Even though the proposed financing dialogue is expected to provide more flexible funding and transparency on voluntary contributions and budget allocations, it does appear a smokes-screen exercise as long as governments do not resolve the zero growth policy of the agency. The dynamic of WHO financing remains the same; only a small proportion of its funding is obligatory Assessed Contributions (AC) while the rest remains Voluntary Contributions (VC). The 132nd EB has suggested that member states explore how the proportion of AC can increase on the long term.[51] Two possibilities to increase sustainable funding for the WHO can be seen. This is either via an agreed level of national revenues to be invested in global public goods and multilateral institutions. WHO could hence be funded for its key role in global health protection and legislation. An alternative would be to develop international taxation for health, from which the WHO (and other health programs) can be financed.[52]

From civil society it is noted that engagement with some regional offices (such as WHO-EURO and PAHO) is easier then with others. WHO could do much more to democratize health at regional and country level. Rather being mainly the technical referent and counterpart for ministries of health, WHO could support and convene policy dialogue and democratic health fora. The Thai national health assembly or the 'Foro de Salud' in EI Salvador, initiated by their respective governments, are good examples.[53] WHO could capitalize on this and initiate policy fora in other contexts via its Country Cooperation Strategies.

Democratizing the WHO is about public trust that the organization and its members will value and consecutively act towards health for all. The political-economic determinants that either undermine or promote progress towards this vision must be made explicit, and it's the critical constructive role of civil society that will continue to do so.[54]

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