Democratising Global Health Coalition on the WHO Reform

Analysis of "WHO Reforms for a health future: Report by the Director General" (EBSS/2/2)

October 2011

The report by the Director General "*WHO Reforms for a healthy future",* released by the WHO Secretariat on 15th October 2011, is the guiding document for the special session of the Executive Board on the WHO reform taking place from 1st to 3rd November 2011. The Board is invited to discuss the proposals contained in the document, for reviewing them, in most cases endorsing them, or giving further inputs and suggestions. This consolidated report – a significant improvement in the quality of the text if compared to the previous fragmented documents released by the WHO Secretariat - looks into three aspects of the WHO reform: 1. The programmatic work of WHO; 2. The governance within the organisation and the role of WHO in global health governance; 3. The management reforms in five areas: organizational effectiveness and resource mobilization; human resources policy and management; results-based planning, management and accountability; strategic communications.

The Democratising Global Health Coalition on the WHO Reform (DGH) has analysed the report with attention. A number of considerations have been identified, based on the DGH analysis. We hope this paper will prove useful for the debate during the coming EB.

DGH's key considerations

1. The rationale for the reform remains very weak. Despite the effort at pulling together previous documents, inputs received from Member States and contributions obtained by the WHO Secretariat in informal consultations in Geneva and elsewhere**, the new consolidated document continues to lack a serious in-depth situation analysis regarding the position of the WHO in global health governance. The need for the reform remains largely unjustified.** Set-up in 1948 as the directing and co-ordinating authority in global health, the WHO must be considered as the global public health policy-making institution; its constitutional mandate is to protect, promote and guide international health work, based on the fundamental right to the highest attainable standard of health for all and health equity. Just a decade ago, the WHO was the one major global-health player. Today, the agency is struggling to assert its raison d'être against a plethora of powerful and often better-funded new players.

While the Report of the DG does not provide any comment on the nature of the current health crisis worldwide and on the reasons for the restructuring of the health paradigm, there is hardly any broad policy overview about the role of the WHO and the new space that has to be created for the organization to better respond to mounting needs.

In the face of the new emerging threats to health, due to

- the global economic and financial crisis
- the climate change and the fuel crisis
- the food crisis
- mounting unemployment and social fragmentation
- migrations and increasing discriminations
- the disproportionate power of the corporate elite

it is apparent that WHO needs a renewed and sound vision about its normative power and intergovernmental identity. No serious commitment for the right to health can be conceived in isolation from a broader approach of universal social protection as a key policy to human development. The programmatic dimension of the reform can only stem from a comprehensive and solid situation analysis, followed by the managerial aspects of the process, and then its financial implications.

The DG report shows instead that the steps of the proposed reform are somewhat, bewilderingly, reversed. So it is difficult for example to craft a well grounded opinion on some aspects of the internal governance of the organization, for example the redefinition of the three levels of the WHO – HQ, Regional Committees and Country Offices – if neither the current landscape, nor the vision for the future role of the agency, are given[1]. The same argument applies to the managerial component of the reform (para 99-120), in relation to the alignment across the HQ, the regional and country offices (para 112).

2. The tension between the collective value of WHO's normative function and governments' individual need for technical support. Funding for global health has grown enormously over the past decade, from US$ 5.7 billion in 1990 to US$ 26.9 billion in 2010, but this money has largely bypassed the WHO because of donors' mounting lack of confidence in the agency[2]. **The current trends demonstrate that most funding has shifted to development assistance for global health, away from the core public health policies and norm-setting role that the WHO has.** This circumstance has significant implications and is not restricted to the health sector alone The recent DFID Multilateral Aid Review (March 2011)[3] identifies *implementing* agencies like UNICEF, ICRC, GAVI and ECHO as having good value for aid money. On the other hand, *norm setting* UN agencies like FAO, ILO and HABITAT are identified as 'poorly' performing. The latest WHO reform paper appears to be written with the DFID review in mind, and geared toward donors and development agencies. In other words, the paper reflects the WHO's endeavour to become more attractive and more competitive in the « tick forest of new influential actors », to regain ground so to speak in its evident and inevitable competition with different entities like GFATM, GAVI and other global health initiatives.

[1] In this regard, arguments elaborated in para 48 of the DG report appear rather superficial and unconvincing.
[2] Butler D., "Revamp the WHO", *in Nature News*, Published online 24 May 2011 | Nature 473, 430-431 (2011) |
[3] http://www.dfid.gov.uk/Documents/publications1/mar/multilateral_aid_review.pdf.

With this donor-driven development approach, **the norm-setting and public health policy role of WHO is significantly undervalued**[4] in the document. While we recognize the need for WHO to reform and reassert itself in the scenario of a globalized world, it should be clear that the WHO's uniqueness as the only entity with rule of law powers on health (art. 2 and art. 19 of the WHO Constitution) is a key feature at a time of "*global health challenges*", and ungoverned transition in global health.

Outcome and impact of this global public health role cannot be directly captured in cost–effective, short term results. They should rather be qualitatively assessed. A key question to Member States, hence, is whether they want to maintain this unique role of the organisation (and provide key contributions for that) or whether they prefer it to be a mere technical organisation in global health, complementary to all the other global health initiatives, and like them primarily depending on a donor-driven, aid-focussed agenda (reference to the Paris Declaration on Aid Effectiveness for health in para 97 is in this respect no coincidence).

3. Risks of undermining the WHO Constitution. Chapter 1 on programmes and priority setting seeks to narrow the work of the WHO to five core areas – health development, health security, strengthening health systems and institutions, evidence on health trends and determinants, and convening for better health.. The reductionist approach of containing the WHO's role to "*what it does best*" (para 23) appears to undermine the WHO Constitution, which clearly outlines the specific functions of the agency. Nobody here argues for duplications, but it is obvious that the WHO should preserve its broad mandate, because even if certain partnerships and global health initiatives do narrow technical interventions better, the cost of fragmentation and lack of coordination they produce may offset the benefits of their technical specialisation. Any additional priorities that need to be defined, as well as resource allocation to this end, are clearly represented in the General Work Programme of the WHO and its various other strategic plans. **The need for limiting WHO's mandate is unclear**, yet several of the proposals contained in the document show how it entails significant potential implications in priority setting, as well as in the governance of the WHO, as illustrated in para 61 and 62, and in para 72, 73 and 74[5]. Countries face different circumstances and WHO needs to be able to support them in addressing their priorities, including through support to Ministries of Health to work towards policy coherence across sectors . These proposals will not only prevent Member States from starting initiatives that may be relevant in view of emerging circumstances, but they will create the conditions for avoiding critical issues simply because they do not fall within the agreed worklans and

[4] The mandated role of the WHO is mentioned twice in the description of the WHO work (para 19) and in the principles (para 87).

[5] DGH wishes to refer to the analysis elaborated by Third World Network (TWN) on the problematic implications of the proposals on resolution drafting in relation to the role of the Executive Board (para 62), as well as on the issue of "agreed conclusions" (para 73.3) and "omnibus resolutions" (para 73.4).

priorities. The risk is also that controversial topics will be politically sidelined with the justification of managerial and efficiency requirements.

We also note that **some of the WHO core functions are not reflected as priority for the organisation**: more specifically, addressing the root causes and environmental, economic and social determinants of ill health. Para 16.5 of the Rio Declaration on the Social Determinants of Health (Oct. 2011) states that "*We recommend that the social determinants approach is duly considered in the ongoing reform process of the World Health Organization*". The DG report hints at the social determinant approach in para 28 and 40, but it does not provide any programmatic pathway on how to concretely engage in this direction.

4. The unbearable lightness of WHO's "widening engagement" . The DG report devotes **overwhelming consideration to health partnerships for the purpose of the WHO reform,** and WHO's interaction with partnerships is regarded as "*a key part of the reform agenda*" (para 96). The document however never mentions the WHO Partnership Strategy adopted in 2010[6]. This appears especially relevant as it deals with conflicts of interest and their identification and appropriate management in case of Public and Private Partnerships (PPPs)[7], including the need for the WHO Secretariat to develop guidelines and operating procedures in this regard[8].

On the other hand, **the proposal to give the Standing Committee on NGOs a say in partnerships needs to be opposed**. The 1987 Principles that guide WHO and NGO official relations makes explicit that the criteria for the admission of NGOs into official relations with the WHO clearly include that *"…the activities of the NGOs shall centre on development work…and shall be free from concerns that are primarily of profit-making or commercial nature"*[9] . Giving the Standing Committee of NGOs a role in partnerships will further lead to confusion as to the roles and nature/functioning of public-interest NGOs vs PPPs.

Furthermore, it is indeed surprising that while WHO speaks of wider engagement, **the DG's paper only mentions civil society organizations once** (para 89, in relation to the multi-stakeholder forum, which is nothing but the World Health Forum in a new disguise) **and continues to fail to deal with WHO's relations with public interest NGOs**. This issue has been raised for decades by civil society but has thus far been ignored. In 2001, the then DG Gro Harlem Brundtland, launched an initiative which reviewed WHO's relations with civil society. In its 2002 report, the review concluded that the 1987 Principles dealing with WHO-NGO relations were inadequate and scarcely

[6] WHA 63.10 and Annex 1
[7] WHA 63.10, para 8(h).
[8] WHA 63.10, para 28.
[9] Article 3.1, Principles Governing Relations with NGOs, WHO Basic Documents, page 78.

relevant to the realities of WHO and to the needs and aspirations of civil society[10]. The Review called for a new policy that would establish principles to distinguish between different kinds of NGOs and their related interests. The Review also concluded that the Policy would consist of: (i) one **Accreditation Policy** to guide the participation of NGOs in WHO's governing meetings. Unlike the present system, accreditation would not be conditional on working relations with the Secretariat, (ii) one **Collaboration Policy** to enhance general interactions between the WHO Secretariat and NGOs including clarity on differentiating between organizations and the role of WHO in supporting Member States work with civil society.

This new policy was discussed at the 2003/4 WHA but it never made it through. The proposed reform now, once again, sets the stage for addressing this issue as a matter of priority, given WHO's currently very poor relation with public interest organizations Member States may wish to integrate in their reform agenda the request to:

- re-launch the Civil Society Initiative and initiate regular dialogues with NGOs;
- define strict but simple criteria and processes for organisations entering into official relations with the WHO (i.e. the accreditation and collaboration process) to facilitate the work of the NGO Standing Committee;
- make a neat distinction between public-interest NGOs and business-interest NGOs, including through badges of different colour for the meetings of WHO governing bodies and other relevant meetings, to limit any confusion and to safeguard the work of governing bodies against conflicts stemming from vested interests.

5. Conflict of interest: the elephant in the room. In para 97 of the DG report, the option of developing "*a framework that can guide the interaction between all stakeholders active in health*" which "*could be modelled on a code or charter, which sets up rights and responsibilities*" is proposed. A much more concrete pathway appears in the four meagre lines of para 188 concerning the suggestion made in the chapter on WHO management reforms to **strengthen "*its [WHO's]overall conflicts of interest policy***" (p 37). It is important that the Board endorses this direction. However, as in other parts of the document, these crucial elements of the reform are not elaborated upon adequately and the EB may wish to emphasize additional points to provide WHO with further guidance.

First, Members States (and the public) need to understand what policies are actually in place. Therefore they may wish to request the Secretariat to provide them with a **full**

[10] See Review Report (2002): WHO's interactions with Civil Society and Nongovernmental Organizations, http://whqlibdoc.who.int/HQ/2002/WHO_CSI_2002_WP6.pdf.

overview of WHOs current state of safeguards for public interests. This would include:

- WHO's definitions of individual and institutional conflicts of interest.
- A set of current policies to address conflicts of interest, in particular at the institutional level.
- Information about where Member States (and citizens) can see policies and documents which are relevant to safeguarding WHO's integrity and independence in interactions with other actors, in particular with those with vested interest (private sector).
- The list of all the Public-Private Partnerships which WHO is currently involved in, as promised to Member States in 2001[11].

Strengthening policies to deal with WHO's institutional as well as its civil servants' conflicts of interest will need much conceptual thinking and require a high level of political commitment. As accredited academics have highlighted[12], **conflict of interest policies are only effective** if they:

- set high standards of ethical conduct
- clearly delineate the unacceptable from the permissible
- develop institutions to monitor behaviour
- impose meaningful sanctions to ensure compliance;
- define remedies for harms caused; and
- provide possibilities for public scrutiny.[13] [14]
- which body oversees this work and where can member states, civil servants and citizens file their concerns and complaints?
- what are its policies to protect whistleblowers?
- what are the post-employment conflict of interest provisions? For example, is there any provision of a cooling off period for high WHO officials before they are allowed to take employment or posts with transnational corporations or other private for-profit sector entities?[15]

[11] WHO (2001). Public-private interactions for health: WHO's involvement. Note by the Director-General. Executive Board, 109th Session, Provisional agenda item 3.2. EB109/4 WHO: WHO, 5th December. http://www.who.int/gb/EB_WHA/PDF/EB109/eeb1094.pdf.

[12] Rodwin M. A., (1993). *Medicine, money and morals: Physicians' conflicts of interest* New York and Oxford: Oxford University Press, 188-189; 209; 219 . Rodwin reveals why the medical community has failed to regulate conflicts of interest: peer review has little authority, state licensing boards are usually ignorant of abuses, and the AMA code of ethics has historically been recommended rather than required. He examines what can be learned from the way society has coped with the conflicts of interest of other professionals --lawyers, government officials, and businessmen-- all of which are held to higher standards of accountability than people in the health sector.

[13] Rodwin, M.A. (1993), *Medicine, money and morals: Physicians' conflicts of interest*.

[14] For additional suggestions by other conflict of interest experts, cf. Richter, J. (2005). *Conflicts of interest and policy implementation: reflections from the fields of health and infant feeding* Geneva: IBFAN-GIFA.

[15] REF. Derek Yach; Ann Venneman

Considering the importance of comprehensive approaches, Member States should also request that the overall conflict of interest policy promotes ' **institutionalised conflict-of-interest impact assessments',** i.e. a proper scrutiny of any proposed new policies, programmes and fundraising activities involving relations with private sector actors. The aim is to ensure that these do not create new unacceptable or unjustifiable conflicts of interest or exacerbate present ones[16].

Finally, the proposal to create an Ethics Unit seems an inadequate approach to dealing with accountability regarding issues of great complexity. Were it to be established, that Unit should have a wider mandate then the currently proposed tasks to '*oversee ethical conduct of staff and administer the declaration of interest policy and procedures' (*para 188). Any such unit should be dealing with *all* safeguards for the agency, including conflicts of interests. Moreover, these should not be limited to individual conflict of interests but also, and more importantly, address the organizational ones. Thus it is desirable that any such Unit be established directly under the DG office, so that the DG would oversee and be accountable for the work of this unit.

6. Collective financing approach: a tool to secure a predictable budget for WHO?

The model of "*the new collective financing approach*" presented in chapter 3 of the DG report should secure *"a shared commitment by Member States to fully finance the organization's priorities."* through an "*inclusive, proactive, systematic, coordinated and transparent process*" (para 131). **This new collective financing approach should be properly explained and elaborated further, and in any case it should be made clear that this approach be complementary to assessed contributions**. Perplexities need to be conveyed, through: would this financing mechanism only follow decisions made by the World Health Assembly or would it also fund objectives deemed as priority by the donors, Member States and non-state donors? What are the safeguards that such a financing model would indeed fund programs based on country needs and not be skewed towards programmes supported by influential players (for instance, the vaccines and medicines development agenda driven by the Bill and Melinda Gates Foundation)?

A structured paper exclusively focused on the financial reform of WHO is still very much required. Finally, the DG report fails to explain the importance that core functions as negotiating global rules for governing health remain funded. The Framework Convention on Tobacco Control (2003) and the International Health Regulations (2005) have shown that this function is becoming more important in our globalized society.

[16] Richter, J., presentation made in Geneva on 13th October 2011 on the WHO reform agenda. Available at www.democratisingglobalhealth.org.

6. Good governance for health starts at home. The DG report focuses on WHO's accountability to Member States and particularly donors but it does not at all address **the issue of accountability and coherence from Member States towards each other, and to the organization**. Just as a matter of example: 1. most Member States ignore art. 61 and 62 of the WHO Constitution*: "Each Member State shall report annually to the organisation"*; 2. Member States are incoherent in that they give importance to the WHO's function in international negotiations, but then they bypass it via bilateral and multilateral health initiatives that have more direct *'value for money*' and have easier cost-recovery mechanisms[17] ; 3. Member States' votes on WHA resolutions conflict with their positions in other multilateral platforms, such as in WTO, WIPO and IMF. This lack of policy coherence needs to be addressed in countries. Member States must take the responsibility of representing the needs and health rights of their people. Unless and until governments have the people directly affected around the decision-making tables, their health policies will remain ineffective. Health democracy, i.e. participation, transparency and accountability in health, is a pre-condition for countries to claim a public interest agenda on health and make an impact in the decision making processes at the global level, within the WHO as well as in other multilateral fora. This means that the WHO should reform while keeping its mandate and functions, but at the same time **Member States need to reform and reinforce their engagement with the WHO**. It is a reciprocal process. Yet, a considerable degree of ambiguity and opportunism is to be recorded by Member States, often against their very interests. It is the Member States which decide now about the WHO's future direction. Their responsibility in the outcome of the process can in no way be underestimated.

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[17] While it might seem at first glance that multilateralism is increasing in health, this new multilateralism is to some degree 'Trojan multilateralism'. Trojan multilateralism refers to cooperation that superficially appears to be multilateral due to the cooperation of two or more governments, yet at closer look is very different to traditional definitions of multilateralism. Evidence pointing to this includes a shift to more discretionary funding of existing multilateral institutions and the emergence of new institutions for global funding that are issue-oriented, vertical and multistakeholder, rather than government-oriented, horizontal and interstate. Sridhar D., Woods N., "Trojan Multilateralism: the changing face of global cooperation". Paper presented at the 52nd Annual Convention on International Studies, 16th March 2011, Montreal, Quebec.