# WHO Reform

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Global health governance:
WHO reform and the Vision of Health for All

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# Outline

- WHO: achievements and disappointments
- WHO: strengths and disabilities
- Different frames of analysis
- WHO reform
- Pathways to real reform

# Nutshell

- WHO is seriously disabled (largely due to the freeze on ACs and consequent donor dependence)
- WHO has been going through a reform program (which has addressed everything except the freeze and donor dependence)
- The global disease burden due to WHO's disabilities is huge
  - the disease burden which would be averted if (the political conditions for) WHO (real) reform were achieved would be huge
- What are those disabilities?
- What have been the achievements and shortfalls of the current Reform program?
- What are the pathways to real reform?

# WHO since 1948

## Achievements

- Smallpox
- Polio
- PIP
- PHC / UHC
- Essential medicines
- Trade & health
- Ottawa Charter / Social determinants
- Marketing of breastmilk substitutes
- IHRs
- FCTC

## Disappointments

- Emergency response (EBV)
- Shortfalls in country level support
  - health services policy
- Pharmaceuticals policy
  - quality use
  - ethical promotions
  - TRIPS flexibilities
  - drug regulation
  - medicines R&D
- Move to ‘multi-stakeholder partnership’ model of program design
  - ‘Counterfeit’ saga

# WHO today

**Strengths**

- Technical authority (plus health as a universal value)
- Treaty making and regulation making powers
- Governance structures; accountability of Sect to MSs
- Staff and rich networks of technical advisors

**Disabilities**

- Donor chokehold: ACs freeze plus earmarked VCs
  - conflicting accountability globally: member states versus donors
- Lack of MS accountability (for health)
- Decentralised governance / conflicting accountabilities regionally

# The global burden of disease consequent upon a disabled WHO

- Health system development in countries
  - universal access to quality health care based on PHC principles
- National action on the social determinants of population health
  - nutrition, patriarchy, economic inequality
- Global policy environment
  - regulation of global food systems
  - regulation of global pharma
  - economic globalisation
    - urban infrastructure
    - communicable disease control
    - neglected diseases (NTDs, diseases with epidemic potential)

# Different frames of analysis

- WHO as singular agent with identified responsibilities
  - GBs pass resolutions
  - Secrt collects data, assembles evidence, produces guidelines, provides advice, organises action
- WHO as a field across which many different agents engage
  - MS: rich versus poor; big vs small; diligent vs slack
  - TNCs: big pharma, big food, big auto
  - Philanthropy: Rockefeller, Ford, Gates
  - Professional organisations: eg WFPHA, WMA
  - Civil society: IBFAN, ‘patient organisations’, PHM
- WHO as agent within a wider field (the global context)
  - the donor chokehold
  - vertical, disease-focused global health initiatives (eg Global Fund)
  - imperialism
  - rising power of TNCs with rampant economic liberalism

# “WHO Reform” (2011 – now)

- Origins
  - financial crisis (due to the ACs freeze and earmarked VCs)
  - the rationale and the promise of the ACs freeze
    - ‘we must restrict funding because of shortfalls in management, priority setting and governance’
    - ‘with reform … maybe…’
  - Catch 22: the degree to which dysfunctions in (management, priority setting and governance) *are actually due* to the freeze and to donor dependence
- Arms of reform
  - management
  - priority setting
  - governance
- Outcomes of reform
  - some improvements in administration
  - the dysfunctions consequent upon the freeze and the chokehold remain
  - the ‘financing dialogue’ institutionalised
  - the ‘multi-stakeholder partnership’ model for program design entrenched

# Real reform

- Unfreeze assessed contributions
- Strengthen member states' accountability for
  - funding WHO,
  - participation in WHO governance, *and*
  - for implementing WHO resolutions
- Build the national and global constituencies for global health
  - mobilise the constituencies who have most to gain from real reform
  - build national and global networks
  - promote a stronger political economic analysis of global health
- Link global health reform to the wider global dysfunctions (imperialism, neoliberalism, growing inequalities)

# Challenges for public health professionals

- Research and analysis
  - understanding dynamics of global health policy making
- Recognition of the need for
  - a strong WHO: properly funded, organisationally coherent, accountable to member states
  - stronger accountability of nation states for domestic and global policy and implementation
- Cultivating the political economy of global health governance as a critical field of teaching, research, and community engagement
- Participation in community mobilisation (and global solidarity) around the right to health