World Health Organization (WHO) reform and its impact in the Global Health Governance.

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Abstract

Global Health Governance (GHG) faces diverse challenges: the gradual transformation from International Health Governance to GHG; the Post-Westphalian World and the multiplicity of actors other than States; and the Global Health dynamics, implicating actors such as International Development Banks and International Foundations that possess resources to implement projects of their own.

Within this deliberation about the new GHG architecture we find the discussions for WHO reform. In progress since 2010, WHO reform talks started as debates concerning the future of the organization’s financing; however, due to the complexity of GHG, these talks merged into questions of the future of WHO’s role in the world.

This paper aims to analyze if the proposed changes for WHO reform will impact GHG, and if so, how GHG architecture will be modified by this renewed WHO. Will WHO be the leading institution in health affairs as it was back in the 60’s and 70’s? Will this reform force the organization to adapt itself to the competitive environment of multiple institutions struggling for Global Health funds available?

Tags: Global Health, Global Health Governance, WHO reform.

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Introduction

Discussions regarding global governance, health and World Health Organization (WHO) reform are not a novelty in the international arena. However, the content of such debate, the actors involved and problems uprising from world changes varied considerably.

Until the 1980’s and part of the 1990’s, international health governance was the type of order identified. As Ng et al. (2011) explain, back in those years most projects concerning international health were bilateral, cooperation was vertical, few actors were implicated and participants’ responsibility was easily recognized and defined.

As the global health concept started being used, so was the idea of a Global Health Governance. Apparently, as there is no consensual reason for the transition from international health to global health, there is not a sharp reason for the transition from international health governance to global health governance either. Different motivations for this change could be pointed out: WHO’s attempt to return to the central scene as the most important institution in health, provided that nowadays there is a considerable number of actors working in the health arena; or globalization consequences in world’s public health, derived from increased people and goods flows, increasing the risk of cross-border epidemics; or the new threats posed by communicable diseases and the international transfer of health risks. Or even a combination of all of this. (Frank et al., 2013; Brown et al., 2006)

There is no consensus either on what can be defined as Global Health Governance. Fidler (2010, p.03) defined it as “the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations, and nonstate actors to deal with challenges to health that require cross-border collective action to address effectively.” Kickbusch et al. (2014), on the other hand, use a very restricted definition of the concept: “institutions and processes of governance that have an explicit health mandate, such as the WHO, hybrid organizations such as the Gavi Alliance (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria
(GFATM), as well as health focused networks and initiatives and non-governmental organizations” (Kickbusch et al, 2014, p.03).

Therefore, Global Health Governance refers to relationships and tasks of specific institutions that work directly with health. This is why the complex relationships in this arena nowadays are divided in two other types of governance: Global Governance for Health and Governance for Global Health. The first one refers to institutions and processes whose work impacts health directly or indirectly, despite the fact that health is not the core activity of such actors. World Trade Organization and International Labor Organization fit into this category. Governance for Global Health is about national and regional institutions and mechanisms contributing to the other two types of governance. Without local support, international efforts for improvements in health quality may become forlorn. As a consequence, all three types of governance are bounded but yet identifiable due to the features of actors involved.

Frenk et al. (2013) also advocate for the use of the term Global Governance for Health instead of Global Health Governance, because the former is much broader and the latter only includes health specialized organizations. In a sense, these authors and Kickbusch et al. (2014) understand Global Health Governance in similar ways.

Recently, in an article at The Lancet, many researchers, in collaboration with the University of Oslo Commission on Global Governance for Health, agreed with Fidler (2010) in what is a proper definition for Global Health Governance. But it is clearly stated in the article the preference for the use of the term Global Governance for Health, because health has got a strong political element, not only a technical part. Global Governance for Health is identified as the achievement of “fair and equitable global governance system, based on a more democratic distribution of political and economic power that is socially and environmentally sustainable “ (Ottersen et al., 2014, p. 633).

What is important to highlight in this discussion is the multiplicity of political arenas that the health domain pervade. And due to this complexity, governance spaces for health face diverse challenges and its architecture is somewhat intricate. Therefore, because of all these different health domains, hereinafter all three types of governance
will be referred to as “health system”, because it is understood that WHO’s reform impacts all these three spheres.

The aim of this article is to discuss why WHO reform process started a long ago and what are the possible impacts of WHO ongoing reform in this complicated health system architecture. WHO reform process and the evolution of the world health system in the last 40 years are described, as well as few academics proposals for improvement of WHO’s leadership in the health system governance. For such assessment, literature on the subject and documents on the issue were analyzed.

**WHO reform: background and current situation.**

The word “crisis” or “reform” are not new at WHO’s vocabulary. From 1948 to the 1990s, brief reforms and little adjustments to the organization’s programs and changes in the financial management system happened, among other modifications (Lee et al., 2014). But in the 1990s, the debate changed, as well as the content of the reform demanded. As Borisch et al. (2013) explains, in the 1990s the world started complaining about WHO’s lack of effectiveness, inefficiency and lack of leadership, especially after HIV/AIDS epidemic broke out. For instance, Stenson et al (1994), in 1994, questioned WHO’s future, identifying that the Organization had its normative capacity as well as its legitimacy eroded, pointing out that a crisis was set.

In 1995, in a brief article, McGregor (1995) unintentionally demonstrates the organization efforts to regain its central position at the health governance, explaining that WHO wanted to approve a new Global Health Charter, linking poverty to ill health. As the author affirms, WHO was considerably worried about debating more than just health in the document, and was also concerned that countries needed time to debate such Charter with ministries other than health ones.

Brown et al. (2006) and Hanrieder (2014) go even further back in time: they recall the crisis to the 1970’s, when development and primary health care entered on the international agenda. Because of that, specific interventions in health lost place for long-
term development plans, and many other actors, including Non-governmental Organizations (NGOs), increased their operations in the health field.

WHO had already to deal with 1950’s – 1960’s Malaria eradication campaign failure, and after smallpox was eradicated in 1979, crisis got worse. Organization’s authority was eroded meanwhile other international institutions were getting a noticeable role in the theme (such as World Bank, UNICEF, UNDP). Civil society also demanded a way to increase their participation, emphasizing how state-centric WHO was. (McInnes et al, 2012).

Literature specifies two main reasons for the Organization crisis. The first one concerns WHO’s bureaucratic institutional design. As McInnes et al. (2012, p. 122) explain, criticisms laid on its “pedant bureaucracy and lack of institutional nimbleness, political nepotism, limited financial resources, overly broad and unfocused mandate, and, above all, its inability to command authority.” Cortell et al. (2008) also emphasize how WHO staff sometimes acted in ways that jeopardized the institution’s relationship with developed countries. Ex-director-general Hiroshi Nakajima administration (1988-1998) made the situation even worse, due to his inability in gaining USA support for re-election and accusations of lack of leadership (Abbasi, 1999). Remarkably, Hiroshi Nakajima developed a reform agenda of his own, focusing on WHO’s adaptation to global change (Lee et al, 2014, p.120). He said that the Organization should be more flexible and, in 1991, affirmed that a new paradigm for health was needed (Beigbeder, 1998, p.28)

The loss of support from some countries – especially the United States of America (USA) - is fundamental as well, and can be understood as the second reason for the crisis. Developed countries considered WHO to be a technical organization, whose activities should be based on biomedical evidences, therefore, WHO was not supposed to politicize any issue concerning health. However, when ex-Director-General Halfdan Mahler launched the strategy “Health for all”, some countries understood that WHO was surrendering to developing countries pressures, provided that by that time they were majority in the World Health Assembly (WHA). USA was very critical to this event, accusing WHO of politicization (Brown et al., 2006; McInnes et al, 2012, p. 127).
American president Ronald Reagan was under pressure from the American Congress, and “made explicit the [US government] discontent with the dominance of Third World countries in UN agencies” (Chorev, 2012, p.125). Discussions about the New Economic Order and African and Asian countries independences affected the balance of power within the World Health Assembly, where the voting system is one country – one vote, and developed countries worried about how strong the primary health debate was getting (Brown et al., 2006). Pressure was enduring: American institutions as Rockefeller Foundation and Heritage Foundation stood against ideas of “Health for All” program (Nuruzzaman, 2007; Birn, 2009). Heritage Foundation even released, in 1985, a report entitled “The World Health Organization: Resisting Third World Ideological Pressures”, emphasizing that the Organization should focus only on technical activities (Beigbeder, 1998; Birn, 2009).

A fact important to be highlighted: not only developed countries were worried about specific projects: WHO program for essential drugs caused “hostility of large pharmaceutical industries” (Beigbeder, 1998, p. 27), demonstrating thus that private actors were also concerned about WHO behavior.

As many authors explain (Cortell et al, 2008; Chorev, 2012; McInnes et al, 2012), politicization of the institution was an important issue. Cortell et al. (2008) explain that developing countries and WHO bureaucracy worked together for the same goals. As a consequence, United States launched the zero growth budget policy in the 80’s, and started, with other developed countries, contributing voluntarily, instead of mandatorily.

This situation intensifi ed with time: in 2012, close to 80% of WHO’s budget corresponded to such voluntary contributions – known as extrabudgetary or earmarket funds (Chorev, 2012; Lee et al, 2014). More recently, in 2013, “the Gates Foundation and the US and [the United Kingdom (UK)] governments were the top three financial contributors to WHO. Roughly five sixths of UK funds and two thirds of US funds were channeled as voluntary contributions, which means the country has control over how it is spent” (Sridhar et al., 2014, p. 02). And the latest information is not different: WHO budget for 2014-2015 is of US$ 4.13 billion, nonetheless, 78% of it comes from extrabudgetary donations. And “80% of these voluntary contributions come from just
20 contributors, 11 of whom are non-state actors (eg, the Gates Foundation)” (Horton, 2015, p.100).

This change in the contribution type was one of the “means by which major donors [had] expressed (…) concerns, by earmarking extrabudgetary (voluntary) contributions for specific purposes”, and the other one was funding more vehemently other institutions (Lee et al, 2014, p. 120).

Developed countries criticized UN as a whole: the organization’s programs, actions and specialized agencies, and WHO was no exception. USA endorsed an agreement that existed since 1964 but was not quite remembered until the 80’s, called Geneva Group. Participants of this group even considered discussing “the problems posed by (…) rapid growth in the activities and budgets of the main [United Nations] Specialized Agencies and the accompanying decline in our influence in the Agencies as their memberships has expanded”. (Chorev, 2012, p.136). Thus, many agencies budgets were reanalyzed, not only WHO’s one.

Even countries’s domestic decisions had an impact at WHO: in 1999, USA approved the Helms-Biden Act, a law known as United Nations Reform Act “that set a number of conditions for the reform of the UN system before the US would release its total amount of arrears in payment to the UN” (Hein et al., 2010, p. 05). This was one of the reasons why WHO started depending on extrabudgetary funds and had to compete with other entities for resources.

To Chorev (2012), WHO faced a crisis while the Organization was trying to get adapted to the neoliberal logic that was introduced to the world arena by the New International Economic Order. Subsequently, its role as main institution in health was lost, due to both organizational flaws as to countries lack of interest (Berlinguer, 1999). There are some other events that indicate such countries lack of interest: for instance, during the 80’s, problems in Health for All strategy implementation occurred because reliable health data and statistics were not provided by the countries (Beigbeder, 1998, p.28).

Either WHO’s excess of bureaucracy’s fault or countries lack of interest fault, a vacuum of power emerged, and alongside it, an institutional dispute. World Bank (WB) was remarkably strengthened: in the 80’s, the Bank criticized Health for All program
and started working with health issues (Brown et al., 2006). During the 90’s, WB budget for health alone scaled up to US$ 2,35 billion, while WHO’s one was US$ 900 million (Nuruzzaman, 2007).

Other entities also became more relevant. Previously, WHO was “seen as the sole authority on global health”, but now the organization is “surrounded by many diverse actors”, for there has been a “population explosion in the [health] system, and there are now more than 175 initiatives, funds, agencies and donors” (Frenk et al., 2013, p. 937). Moreover, other UN agencies also impact indirectly health issues and Public Private Partnerships (PPPs) became part of the plurality of agents that act in global health nowadays as well (Fidler, 2007). Multiplication of actors scaled up to a point that, today, “there are over 26 UN entities, 40 bilateral development agencies, 20 multilateral development funds and 90 global health initiatives”, besides many PPPs and multinational companies working with the theme (Hoffman et al., 2014, p.190).

Dealing with a diminished budget and confronted leadership, WHO structured a reform already in the 90’s. In 1992, the Executive Board established a working group that developed 47 recommendations to be taken by the organization (WHO, 1995). From 1993 to 1996, all WHA sessions debated WHO’s crucial adaptation, and discussions emphasized regional offices and head office managerial improvement, intensification of programs efficacy, increment and expansion of actions implicating both WHO and member states, improvement in communication and staff reduction (WHO, 1997). The Executive Board, in turn, debated how to assess programs and priorities bearing in mind the budget, the technique and the resources available (WHO, 1995).

In 1995, at the 48ªWHA, even modifications in WHO Constitution were considered (WHO, 1997). The Assembly asked the EB for a review on it, and in 1996 a special group was established, holding six meetings from 96 to 97. This group suggested some adjustments, among them “tightening the sanctions relating to non-payment of financial obligations” (Burci et al., 2004, p.18). As Burci et al. (2004) highlight, group’s proposals were not accepted; therefore, the Constitution remains pretty much the same. The 51st WHA and the 52nd WHA also tried to introduce changes to the Constitution too, however, only few changes proposed by the 51st were accepted. (WHA, 1998; WHA, 1999).
By the end of the decade, when Dr. Gro Harlem Brundtland was elected Director General, the aims of the institutional reform took a different turn. Commission on Macroeconomics and Health was created in 2000, and the relationship between health and development was further emphasized, as well as WHO’s relationship with the Bretton Woods institutions (CMH, 2001). The new Director General also sought the improvement of WHO’s finances, therefore, PPPs were stimulated and private entities contributions were further promoted (Beigbeder, 2010). As Chorev (2012, p. 189) underlines, Dr. Brundtland understood that to co-opt with other organizations was a better strategy than to compete with them.

Birn (2009) strongly criticizes this WHO attitude of coming closer to PPPs and to Bretton Woods institutions. As the author affirms, the Organization efforts to return to its position of main institution in the health system actually echoed WB’s argument of health as a way to promote development; health thus was seen through the lenses of economic productivity.

Despite all this criticism, shortly after Dr. Brundtland administration began, only few documents had the word “reform” written in their contents. This fact can be analyzed examining WHO’s documents available at WHO’s Institutional Repository for Information Sharing (WHO, 2014a). At this website documents from almost all WHA since 1948 can be found.

Although the word “reform” is quite not used, it can be inferred by many documents that WHO kept on discussing how to strengthen institution’s programs, to develop new partnerships – with NGOs, PPPs and private institutions – and to improve Organization’s management (and management in these documents is understood as more substantial financing and better use of the resources, employees dismissal, better communication methods with regional offices and meetings with individual countries). There was indeed an institutional effort so that WHO could adapt itself to this new health system scenario (WHO, 2014a).

If the neoliberal standards and budgetary issues are considered to be WHO’s first crisis, then a second crisis can be observed after 2008 world financial problems and Influenza A pandemic (2009 – 2010) (some authors argue that this second crisis is
actually a result of problems in operational and financial issues, therefore there is no consensus for the reasons of this crisis yet (Ventura, 2013)).

A second reform cycle began, and WHO financing debate got more substantial. As Ventura (2013) assesses, finance can be considered the trigger for the reform impetus: in 2010, an informal consultation with country-members and “regional offices [occurred], resulting in several critiques to the institution’s financial management” (Ventura, 2013, p. 109).

Further documentation analysis indicates that not only financial issues were debated, but also WHO projects and leadership as a whole. The 64th WHA, in 2011, focused on 3 goals for the organization changes (WHA, 2011, p.01):

“ (1) Greater coherence in global health, with WHO playing a leading role in enabling the many different actors to play an active and effective role in contributing to the health of all peoples.

(2) Improved health outcomes, with WHO meeting the expectations of its Member States and partners in addressing agreed global health priorities, focused on the actions and areas where the Organization has a unique function or comparative advantage, and financed in a way that facilitates this focus.

(3) An Organization which pursues excellence; one that is effective, efficient, responsive, objective, transparent and accountable.”

These 3 goals were later considered to be the 3 pillars or strands of WHO reform: programs and priority setting, governance and managerial reform (Ventura, 2013). For each of these strands, WHO Executive Board developed a program with detailed elements concerning what changes should take place and how should they take place – for instance, in the governance strand WHO suggests that the organization should be more inclusive so that different actors have their voice heard by the institution and, as a consequence, WHO would become a leader in this dialogue (EB, 2011).

In 2012, WHO defined reform costs, strategies and goals; and also specified what each one of the 3 pillars would contemplate. The development phase alone had an
initial budget of USD$6.2million. Regarding programs and priority-setting, countries decided that the organization should prioritize criteria such as states individual needs, internationally agreed instruments and comparative advantage of WHO, among other ones. They also determined that WHO works should be focused on communicable and non-communicable diseases, health promotion, health systems, preparedness, surveillance and response and corporate services/enabling functions (WHO, 2012, p.06)

Managerial reform focused on WHO internal improvement, concentrating efforts in themes as human resources, efficiency intensification, institutional communication, organization’s oversight, accountability and evaluation (WHO, 2012). Despite WHO necessity for improved relationships with multiple actors working with health issues nowadays, these two pillars description demonstrate a concern and an apprehension by the organization regarding member states judgment on the institution. Adjustments seem to be made so that WHO may act as countries want it to, as well as there seems to be a need to demonstrate that the organization, as any liberal-world enterprise in the planet, is efficient in what concerns cost-benefit and transparency to stakeholders (in the case, countries too).

Regarding governance reform, this last pillar focused on the improvement of internal governance of WHO as well as the institution’s role in global health governance. This part of the reform was divided in 5 high-level areas and 15 specific outputs, all of them related to improving the relationship with governing bodies, member-states or stakeholders (WHO, 2012)

A crucial part of the governance reform deals with the organization’s relationship with non-state actors. Member states demonstrated preoccupation regarding due diligence conduction, private entities donation of resources to WHO, relationship among private institutions and non-private institutions (as NGOs, philanthropic institutions and academy) and how all these actors would engage in relationships with WHO (EB, 2014a). The Organization herself is aware that such engagement represent risks, encompassing even WHO’s reputation and credibility (EB, 2014a)

On December 2014, the Executive Board published a document specifying how engagement with non-state actors would occur, establishing, as annexes to the official document, draft frameworks on how such action would take place and how policy and
operational procedures would be like. Interestingly, each annex explains policies and operational procedures on engagement with each type of non-state actors (non-governmental organizations, private sector entities, philanthropic foundations and academic institutions) (EB, 2014a).

As the document states, WHO will only accept resources of private entities that do not confront organizational principles, and contribution made by them shall not be used for normative work, neither afford privileges or advantages to these actors (EB 2014a). All contributions portrayals will be open to the public.

A relevant fact to be highlighted at this point is that, in the whole EB document that explains how WHO will engage with different non-governmental actors, it is clearly stated that WHO will not engage with tobacco and arms industries whatsoever, and that Member States understand that the same restriction should be extended to alcohol, food and beverage industries as well (EB, 2014a, p.03). The word “Pharmaceutical” only appears in a footnote at the end of page 30, specifying that WHO will only accept medicines donations that respect guidelines previously set by WHO and other federations, including the pharmaceutical one.

Thus, a question considering why WHO does not further specify how its relationship with Pharmaceutical Industries will be dealt is raised. Member States demonstrate their will for WHO not engaging with alcohol, food and beverage industries, and the International Organization (IO) and pharmaceutical industries already have an intense relationship, so why not to improve legislation and create norms so that such relationship is more transparent.

WHO admitted, on December 2013, that only 39% of the reform goals had been fulfilled (WHO, 2014b). And although WHO, in a document from May 8th 2014, demonstrates an evident effort in the managerial reform pillar. Programs and priority setting obtain due attention because of projects and budget relationship, and the governance strand is worked upon greatly because of the large number of actors in the health governance system. However, WHO made quite clear in the document that without resources and countries support, these last two pillars are impaired. (WHA, 2014).
Past year, on December 2014, another reform overview was made available by the organization, this time for the 136th session of the Executive Board. Such report demonstrates that, by October 2014, 64.5% of the reform outputs reached the implementation phase; however, when the analysis is divided into the three proposed areas to be changed, only in programs and priority-setting 100% of the outputs are already in the implementation phase. In the management area the number goes down to 65%, and in governance the percentage is the worst one: only 43% (EB, 2014b).

Funding, the essential part of the reform, is also under discussion. A document from the Executive Board, dated from December 24th, stated that inquires stressed that “Member States should remain the primary funders of WHO”, and more than that, by no means should voluntary contributions stop. WHO recognizes that assessed budged represents a small share of what the institution needs. And not only countries would be able to keep on contributing with earmarked funds: private actors would be able as well. As a matter of fact, WHO is willing to optimize “the funding relationship with the top 20 contributors, focusing on areas of alignment between their priorities and those of WHO”, and also increasing accountability with member states so that engagement with contributors is increased (EB, 2014c, p.03 – 04). In this document WHO even states that “the willingness of Member States and other contributors to provide voluntary contributions will reflect their confidence in the Organization” (EB, 2014c, p.04).

WHO reform is yet ongoing, thus its direction and probable aftermath are hard to be sharply predicted. What seems to be happening is WHO understanding that extrabudgetary funds will still be needed; that member states need to be brought closer to the decision making processes and participate in WHO goals formulation or they will fund another institution that meet their particular interests; and that there are more private institutions dealing with health issues, therefore, it is better to have them closer so that their actions can be understood.
Possible theoretical explanations for WHO reform and solutions proposed by the academy.

Some studies about international organizations activities have scrutinized WHO’s behavior and its change, for instance studies of Cortell et al (2008) and Hanrieder (2014). The authors aforementioned structured their analyses with different perspectives and use distinct theories to do so.

Cortell et al (2008) investigate the topic using principal-agent theory, whose main pillar is that principals and agents are mutually constitutive, provided that, through the processes of delegation, “a conditional grant of authority” is ensured to the agent by the principal, so that the “the latter [is empowered] to act on the behalf of the former” (Hawkins et al, 2008, p.07). According to the authors, WHO’s actions since its creation were consistent with countries will most of the time. Nonetheless, because of WHA voting system (one country - one vote) and of its international technical staff (not only personnel appointed by member states), WHO developed an increased likelihood of acting not exactly as all the countries wanted, causing what is defined as “agent slack”, “independent action undesired by the principal” that is usually the result of different preferences (Cortell et al, 2008, p.256).

Although it seems that, because of WHO’s institutional design, the organization is prone to slacking constantly, competing interests and different motivations and perspectives for action are much more likely to happen than slack. The authors themselves explain that WHO did not act as countries expected only twice, because of communicable diseases alerts not authorized by the states (Cortell et al, 2008).


According to Orchestration theory, International Governmental Organizations (IOGs) have moderate governance capacity and sometimes difficulties to accomplish tasks because they are “constrained by restrictive treaty mandates, close member state
oversight, and limited financial and administrative resources” (Abbott et al., 2012, p.02). Orchestration is an IGO enlisting and supporting “intermediary actors to address target actors in pursuit of IGO governance goals” (Abbott et al., 2012, p.02). Their point is that third parties are involved in the governance by the IGOs (also known as orchestrators) so that such third parties are the ones governing what the authors define as target. Orchestration is an indirect way of governance, a soft mode, and should not be understood as a hierarchical way of dealing with the world order, but as the integration of a multi-actor system instead, a system in which neither orchestrator nor intermediaries would be able to achieve their goals alone (Abbott et al., 2012).

These goals may be regulation of behaviors or provision of public goods, and these intermediaries include a rather diverse range of actors, such as NGOs, “business organizations, PPPs, transgovernmental networks and other IGOs”, and they “are crucial to orchestration because they possess governance capabilities – such as local information, technical expertise, enforcement capacity, material resources, legitimacy and direct access to targets – which the IGO lacks” (Abbott et al., 2012, p.03).

Intermediaries are important when IGOs need local information, and they help these Organizations to get closer to private actors without state intermediation. States cannot be considered a problem, though, for they may incentive IGOs and intermediaries to orchestrate, particularly if they “have weak mechanisms of oversight and control”. (Abbott et al., 2012, p.20) IGO working theme also influences state control: “states are more likely to impose strict control on IGO independence in core areas of national sovereignty, such as defense or fiscal policy, than in low politics areas such as environmental protection, development assistance or disaster relief” (Abbott et al., 2012, p.20)

As Hanrieder (2014,p.191) affirms, “WHO was created to be an orchestrator”. WHO is a focal institution, which means that it competence in health issues theoretically incomparable to any other institution. WHO has got orchestration properties, albeit its loss of focality in some health domains due to the multiplicity of actors such as in the health assistance area. There are three characteristics in an orchestrating IGO: a principal-agent design, a bureaucratic entrepreneurship and capabilities of properly working on its core issue. Despite the fact that WHO engages in
soft governance, the organization staff holds “a strong professional identity and independent expert authority” (Hanrieder, 2014, p. 195).

Hanrieder (2014) develops the idea that WHO orchestration can be divided according to different themes, because in technical health assistance WHO has lost its leadership and effectiveness, nonetheless, on the other hand, WHO was fundamental when problems were about infectious diseases.

Until 1970’s, WHO was the main institution dealing with technical health assistance. However, when in this same decade health was linked to development and the Organization started working with the concept of primary health care, many other institutions got involved with health, provided that this association with development connected health to social affairs. NGOs, World Bank, UNICEF and even PPPs were some of these new institutions, and the utmost consequence of all this processes was WHO’s loss of focality in the issue.

Although the collaboration established by all these actors, so that they could establish partnership in projects, the main consequence was that WHO became “only one among many, and certainly not the dominant orchestrator” (Hanrieder, 2014, p. 202). Such loss of focality also weakened countries’ perceptions regarding the importance of the Organization.

On the other hand, in what concerns communicable diseases combat and control, WHO did not lose focality. Intermediaries for monitoring and information access support exist, and after members states revised the International Health Regulations (IHR) in 2005, “they provided the legal basis for autonomous WHO orchestration in disease surveillance and response” (Hanrieder, 2014, p. 209). In a nutshell, IHR empowered WHO.

Such question should be elucidated. Why in a more political issue, as health assistance and primary health care, WHO lost its focality and became one institution among so many others competing for resources; and in a more technical issue, as communicable diseases control, WHO became the main orchestrator? This divergence should be thought through by International Relations analysts.
Regarding the theories here presented, both emphasize IGO oversight and accomplishment of goals previously set, however, by no means the orchestrator is the principal in the relationship with intermediaries. These theories seem to be entangled but should not be confounded.

Because of the observed problems at WHO and of the theoretical explanations for the lack of leadership in the global health system, academics attempted to develop solutions to improve the global health system governance and deal with consequent problems.

As Hoffman et al (2014) highlight, WHO’s institutional design challenges are not dealt by countries; states created new organizations instead, for instance UNAIDS (Hanriender, 2014). If in one hand the technical part of the organization’s secretariat needs more autonomy, in the other one this same secretariat needs its “capacity to support political stewardship” boosted. (Hoffman et al., 2014, p.190 - 191). Because of this separation, some authors have introduced the idea of splitting WHO up into two institutions, one technical and the other one political, since this combination of technical / normative / multilateral institution is no longer able to deal with current governance problems (Hoffman et al, 2014; Lee et al, 2014). Even WHO’s regional offices would change: they would become technical bureaus or would “be dismantled” (Hoffman et al, 2014,p. 191), leaving for the countries to decide how local governance for health issues should be structured. Executive board and Director General would be split up as well, while WHA would still be one but would look after the two entities.

Regardless these ideas of dividing WHO in two, the organization’s reform does not consider this possibility. Although Lee et al. (2014) argument that there has been a disconnection between what the internal reform agenda has settled and a new world demands since the 1990’s, and that there has also been disconnections between WHO’s original mandate with its current activity (a dilemma resulting from funding necessity, provided that it is easier to get extrabudgetary funds for specific programs), WHO documents indicate that reform attempts to meet world new demands, not to split the organization up into new entities (WHA, 2011; EB, 2011).
There are other ideas for WHO too. Mackey et al. (2013), bearing in mind the number of UN agencies involved with health issues and inspired by what happened in the 2011 UN High-level Meeting on Non-communicable Diseases, proposed the creation of a UN High-level Panel on Global Health. All actors in the health system would participate in such Panel, from NGOs to patient groups and health-related industry representatives, besides UN system organizations. WHO would be the chair and Panel meetings would coincide with WHA’s ones. The Panel would also have a fund, developing programs of its own and having a specific budgeted, demonstrating here that this proposal has got a clear aim of avoiding that WHO keeps on being bypassed by other institutions and of reducing or even cutting off extrabudgetary funds. However, this Panel accountability, authority and legitimacy need further discussion, as well as its possible impact in WHO importance and programs as a whole.

Instead of a UN High-level Panel on Global Health, Gostin (2007) proposes a Framework Convention on Global Health (FCGH). The author emphasizes that WHO constitution allows the organization to greatly influence international law. The institution is technical, indeed, but is also a leader in influencing norms creation. Even WHO understands that the institution has got a role in global health system governance and that such role is an actual expression of its constitution (EB, 2013). In a Framework Convention, according to the author, international law could be used as a channeling mechanism for cooperation. The FCGH would have principles and financial resources of its own, as well as flexibility and ways of guaranteeing countries commitment to the health regime (as monitoring and enforcement). The problem of such Framework Convention, though, is that for its institutional structures activities, empirical monitoring and enforcement mechanisms would be necessary. Therefore, disputes settlement and ways of sanctioning would have to be defined.

The most interesting characteristic of these different ideas proposed by academic is that all of them emphasize WHO’s central role in the health system governance. None of them propose WHO dismantlement: they actually try to take what they consider to be the best part the organization (whether its importance in combating communicable diseases or its normative capability) and underline it in a way that WHO recovers its pivotal role of decades ago.
Health system architecture and WHO reform

The architecture idea is a metaphor used to explain health system governance. Such metaphor is possible because, according to Fidler (2007, p.03) “governance involves crafting ways to achieve political interests and values”, as well as impediments and limitations that may be part of the structure of a defined system. However, the same author analyses that there actually is an unstructured plurality in such governance, and that since 2005 there has been a discussion regarding how should a new architecture for health governance be like.

Chorev (2012) describes the health regime instead of its architecture, and draws a progressive line demonstrating the processes and changes that took place from the 70’s to the 2000’s. As the author demonstrates, previously WHO was an institution focused on social development, equity, horizontal interventions and basic health needs, with a public health perspective and with a budget constituted by member states mandatory / assessed contributions. From the 1990’s onwards, the logic changed. Economic issues and disease specific interventions became central to the institution rationale, as well as extrabudgetary contributions and private sector mentality (Chorev, 2012, p. 230).

From 1998 to 2003, this global health system architecture grew both in size and complexity, mainly because of WHO Director-General Brundtland administration; definition of the Millennium Development Goals and multiplication of actors dealing with health. During the 90’s, took place as well an increase in the amount of resources available of health programs; the multiplicity of actors made more difficult the delineation of a clear line of responsibility, efforts happened to overlap and coordination was lacking. As a consequence, 2003 onwards period marked a change in WHO’s role in such architecture (Lidén, 2014).

All these changes that got started at the 90’s can be considered challenges to the global health system as a whole. Some authors further specify these problems:
Kickbusch et al. (2014) clearly describe them: competing interests and fragmentation; need for countries greater commitment; definition of the role of private actors; warranty of private sector accountability; reliability of the funds granted to the institutions; warranty of political support; warranty that the civil society voice will be heard and lack of organization – strategies are not established in an organized fashion or centrally implemented.

Effectiveness, equity, efficiency in achieving outcomes, and credibility and legitimacy in decision-making processes needed for good governance are also hindered by other global health problems: sovereignty challenge, sectoral challenge (multiply sectors in a interdependence relationship) and accountability challenge (Frenk et al., 2013, p.939). These mentioned challenges halt the global health system to completely fulfill its purpose: produce global public goods, manage externalities across countries, mobilize global solidarity and stewardship (Frenk et al., 2013, p.940). Authors Ng et al. (2011) point out another problem: the lack of well-delineated roles for actors participating in this governance. They affirm that there are three easily identifiable functions: funding, channeling assistance and implementing programs. However, not rarely different actors play the same role, overlapping efforts.

World order issues also impacted this global health system governance after 2003-2005. Fidler (2007) and Chorev (2012) explain that nowadays there is a new world order, post-westphalian and post-liberal. As a consequence of this post-westphalian world, territory importance diminished, more complex inter-boundaries relationships were established and non-state actors demanded more representation and more room of maneuver in international politics.

Moreover, the world faced a considerable economic constrain: the global financial crisis in 2008-2009, and such crises impacted greatly health too. It resulted in a diminution of resources available for health development assistance. Even World Bank loans decreased in 2010-2011 (Mackey et al., 2013). Global power was different too: G20 became more important than G8 and developing countries were assembled in different groups demanding more participation in the world scene (as the BRICS), meaning that power in the international scene was much different than it was in the 70’s (Borisch et al., 2013).
Architecture problems imposed challenges to WHO. Apparently, there is an understanding that WHO is central to the system and “the only actor that is built in the universal membership of all recognized sovereign nation states” (Frenk et al., 2013, p. 937), with a unique political legitimacy, and despite the fact that its resolutions or documents are non-binding and the organization cannot enforce countries compliance, WHO deals with quintessential health regulations, such as IHR, Framework Convention for Tobacco Control and counterfeit medicines (Sridhar et al., 2014).

Nonetheless, despite such understanding of centrality and legitimacy, the organization suffers with the already mentioned lack of countries commitment and its relationship with the private sector still seems to be unclear. Since Director General Brundtland administration, business participation and partnerships are welcome, both for money and for knowledge (Chorev, 2012, p. 189). Private sector could be part of the solution to Dr. Brundtland, and she also considered that WHO should not only look to traditional allies, such as UNDP and UNICEF, but also to financial institutions and to NGOs (Chorev, 2012, p.191). Plus, cooperation with the private sector could be seen as an indicator of WHO inefficiency diminution (actually this perspective was valid to all the UN system, if seen under USA government perspective) (Chorev, 2012, p.192). And developing countries, in the end of the day, understood that WHO needed to be “the vanguard of health”, and many member states realized that WHO “had no choice but to support the trend toward public-private partnerships and to involve the private sector” (Chorev, 2012, p.194).

Already in the year 2000 there was some preoccupation regarding such WHO proximity with private market. At the same time that countries wanted the organization to develop a better relationship with the private sphere, they worried that WHO would have its autonomy weakened. Besides, WHO relationship with all these multiple actors is asymmetrical. Such private sphere includes actors with completely different capabilities, stories and resources. How to guarantee that ONGs and private entities will influence the same? How to guarantee that WHO will be able to deal with NGOs and pharmaceutical industries in similar ways? As Martens (2003, apud Richter, 2012, p. 146) asserts: “it is problematic to use the term “partnership” [and ‘stakeholders’] to characterize the relationship between state and non-state actors, because what the term suggests is an … equal status for the actors involved. This relativizes both the special political status of governmental institutions under international law and their
(democratic) legitimacy. It implicitly downgrades the role of governments and intergovernmental organizations and upgrades the (political) status of private actors (…)

Another challenge must be added to this long list, and it prominently affects WHO and global health system governance: communicable diseases. Epidemics play a central role in the global health system architecture and have severe consequences for WHO’s performance and interaction with other actors. Past examples vary: SARS episode strengthened WHO, as Lidén (2014, p.145) debates: “SARS epidemic in 2003 re-established WHO as a global authority and coordinator on disease outbreaks”. Avian influenza, influenza A, and Ebola, on the other hand, put WHO and its weakened reaction on the spotlight. In the Ebola case, the organization itself affirmed that “the outbreak of Ebola virus disease in West Africa in 2014 has had a significant impact on WHO and on reform implementation, and has revealed areas in which further reforms may be required to ensure the Organization is able to respond rapidly and effectively in emergency situations” (EB, 2014b, p. 01).

WHO secretariat admitted that mistakes occurred during the Ebola outbreak. But countries and donors, instead of finding WHO guilty and blaming the institution for all the problems, should understand the importance of this organization to health in the world and the effects of past funds cut. As professor Jeremy Youde stated in the Washington Post of August 8th, 2014: “The Ebola outbreak is exposing the weaknesses in the World Health Organization and its ability to be a leader in responding to global health issues, but many of these weaknesses result from constraints imposed by member states. (…) If we want a WHO that can respond more quickly and with more resources, the international community has to be willing to support such an organization.”

Summarizing, global health system architecture today is more private, with diverse types of actors and is facing economic constrains. And within this architecture is WHO, whose reform is trying to recover institution’s central authority and to grasp how to interact with so many different actors (Lee et al, 2014, p. 121).
Regarding WHO reform and bearing in mind all afore mentioned, analysis may deduce that all three spheres of the global health system would be affected by WHO reform. Global Health Governance would be affected because WHO is yet the most important institution among all the ones working exclusively with health. It has got international legitimacy to perform its tasks, and an institutional strengthening resulting from the reform would further emphasize the role of WHO as an orchestrator and as a leader with technical expertise to say what the world needs to solve health problems. Governance reform strand here is the fundamental one: if WHO improves its relationship with member states and defines clearly how relationships with non-governmental and private actors will take place, the organization will indeed promote policy and operational coherence in global health, as well as cooperation for better health outcomes.

Governance for global health would be affected as well, mostly by managerial reform, because this particular strand of the reform deals with WHO regional offices. Strengthening of these regional institutions and improvement in communication with WHO headquarters would increase activities effectiveness as a whole. Programs and priority setting pillar would also impact regional offices role and WHO local influence, because WHO support to the improvement of member states health quality would intensify. This could, as a consequence, also improve WHO’s relationship with countries.

Perhaps the part of the global health system that would be greatly affected would be the Global Governance for Health. Reform would define in a clearer way the roles and relationships of WHO with different institutions; and that includes affairs with the ones not working exclusively with health, as the World Bank. All this would probably diminish other institutions political room of maneuver, in terms that would diminish their own programs formulation and, consequently, their demands for countries to respect national adjustments to be granted with loans. However, with WHO as the leader and orchestrator, health policies and health targets amongst different actor would converge much more often, therefore, such diminution probably would not impose health drawbacks.

But for all that to happen, WHO needs budgeted and non-earmarked funds to work with a level of autonomy that allows the institution to meet world health priorities.
Without required resources, WHO will not play the role in health that many expect it to play, the institution will not be an effective agent if principals do not want it to.

**Conclusion**

Should WHO reform be defined in only one phrase, such phrase would be commitment. WHO committed to being more efficient; member states committed to funding the organization properly, not only with earmarked contributions; and all the other actors committed to effectively compromising with health outcomes.

There is no doubt about one thing: WHO has got technical leadership. And in the developing world, the institution is still very influential (The Lancet Editorial, 2009). WHO reform is pretty much based on financial issues and institutional improvement, but the organization needs to achieve financial stability as soon as possible so that its programs outcomes are as previously set (Kamal-Yanni, 2012). WHO has got the expertise, but requires funds to implement all the projects (Gostin, 2007).

This debate has different branches and clusters to be further analyzed, as well as the need for further discussion with International Relations theorists. Theories as principal-agent and orchestration could contribute greatly to the development of better ideas for WHO and, consequently, for the global health system governance as a whole.

Unfortunately, member states seem to not quite agree on what kind of Organization they want and what kind of activities they want WHO to develop. As Richter (2012) analyses, WHO reform is actually part of a bigger scene: not only is this institution trying to adapt itself to the post – liberal world. The UN system as is whole is attempting to do so, restructuring activities and institutional design so that relations with business are improved. There is a demand transparency in this process so that the world can understand private entities behavior.

Another point that should be born in mind throughout the whole reform process is the importance of WHO constitution. No matter if the reform continues focused on the three pillars already mentioned, or if a Framework Convention is created; WHO
constitution is central. Therefore, new proposals should always be analyzed and developed in the light of this legal document, in order to not undermine WHO’s core functions. WHO has got a fundamental normative power, despite the fact that there are not many mechanisms in international law related to global health as there could exist. (Gostin, 2007, Richter, 2012).

Private actors have already stepped in the health system arena, and WHO needs to have some sort of leadership (as orchestrator, for instance) so that all different entities with different funds and distinct aims understand not only that there are some few rules to be followed, but also common goals that will improve health as a whole. For example, Global health initiatives have had positive impacts in health outcomes, more people have access to medicines (including antiretrovirals). However, negative impacts also exist, such as diminution of countries’ domestic expenditures on health and decreased service quality due to strict targets to be met (The Lancet Editorial, 2009). What all these global health initiatives should seek is an improved relationship amongst themselves, WHO and also with the country populations they work for; and WHO could, in such case, play a fundamental role of coordinating these initiatives with countries’ demands so that positive impacts were ameliorated (Kamradt-Scott et al., 2015)

WHO needs to be funded properly. But not only resources are needed: WHO needs political support too, both from member states and private entities. And even with all these difficulties and struggles to develop and implement its programs, WHO can still account positive records on its institutional story, for instance, as affirms Hein et al., (2010, p.05) “WHO has partially regained its central position in recent years. It has increasingly assumed a more active role in global health diplomacy, particularly through the successful negotiation of two important international agreements, the Framework Convention on Tobacco Control (FCTC) and the new International Health Regulations, which played an important role in the coordination of the control of SARS, the avian flu, and the “swine flu” (Pandemic Influenza)”

Apparently, due to all these changes in the health system, the World Health Organization will not be the same institution it was in the 70’s. And this will happen not because WHO is incompetent, or because it has lost its importance in disease prevention and combat. But mainly because both the world order and the global health system have
changed. WHO reform will impact health governance in all its different types, but WHO’s mentality need to change as well: more than an orchestrator, WHO should be a mediator among all these different interests and goals. More than a leader, WHO should became a reference for all actors implicated in global health.

References:


