Resuscitating a comatose WHO: Can WHO reclaim its role in a crowded global health governance landscape?

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WHO has been guilty of complacency and taking its unassailable leadership role in global health for granted. The WHO's governing bodies are currently engaged in a programme of reform in an attempt to resuscitate the lethargic and archaic organisation. This paper highlights both the internal and external issues facing the WHO and the proposed solutions to these problems and their feasibility of success. It concurrently argues that WHO remains vital to global health governance and in giving low-income and middle-income countries a voice in global health, and outlines its unique role and why it should not be cast aside. Given the likelihood that truly radical change is unlikely to happen, the paper proposes some practical, incremental, achievable and realistic strategies that will allow the WHO to regain its leadership role in global health. WHO must shift its functions to regions, further utilise its rule-making powers to create legally binding agreements, diversify its funding sources, and embrace its capacity to become the knowledge broker and coordinator of global health.

INTRODUCTION

The World Health Organisation (WHO) is facing an unprecedented crisis, related to severe budgetary problems and a struggle to identify and maintain its role in a crowded global health governance landscape. Dr. Margaret Chan, Director-General of the WHO, has stated: 'WHO is overextended and unable to respond with speed and agility to today's global health challenges.'[1] This crisis has led to WHO undertaking an internal reform process in an attempt to reclaim its leadership role in global health. The WHO needs to rediscover the 'why' of its own existence to enable it to decide on the best 'how to' strategy for achieving its noble mission.

WHO IS THE WHO? ISSUES FACING THE ORGANISATION

External issues

A crowded global health governance landscape

The WHO was established post World War II amidst the Cold War era in 1948 and was arguably the only player in global health. As outlined in the WHO's Constitution, the organisation's function includes acting 'as the directing and co-ordinating authority on international health work' and promoting 'cooperation among scientific and professional groups which contribute to the advancement of health.'[2] However the WHO now finds itself attempting to operate in a global dynamic of 'unstructured pluralism'[3] for which it was not designed. New organisations overshadow the WHO, including modern global health initiatives (such as the Global Fund to Fight AIDS, Tuberculosis

and Malaria ('The Global Fund') and the GAVI Alliance), bilateral programmes (such as the United States President's Emergency Plan for AIDS relief (PEPFAR)), well-funded philanthropies (such as the Bill and Melinda Gates Foundation) and technical institutions working in areas which were previously the 'monopoly' of the WHO (e.g. the Institute for Health Metrics and Evaluation, (IHME)). These new initiatives are well resourced and therefore operate independently, and do not need to rely on support from organisations such as WHO to set their agenda**.** For example, the Global Fund provides roughly 20 percent of international public HIV/AIDS programme funding, 65 percent of malaria funding and 65 percent of tuberculosis funding for 22 high burden countries.[4] Meanwhile, WHO's combined assessed and voluntary budget is at the same level as the operating budget for the Massachusetts General Hospital, just one American hospital.[5] The WHO is no longer setting the agenda of global health; instead, it is struggling to keep up.[6] WHO was once the main source of global health data, but now, although controversial, the IHME has produced the landmark Global Burden of Disease Study 2010. It is considered the most comprehensive description of the totality of death and illness in every part of the world, yet WHO did not contribute to it.[7] In reality, the global health governance landscape has dramatically transformed over the past 64 years, while the WHO has not. It is time that the WHO reforms to ensure its relevance and reclaim its leadership role.

The global financial crisis

While internal financial issues are discussed in more detail below, the ongoing worldwide financial and monetary crisis is another external factor which has contributed to WHO's budgetary woes. Financial constraints within Member States have resulted in reduced WHO contributions, slow payments and a zero nominal growth situation in the organisation's budget.

Internal issues

WHO governance

While a lot has been written about the unstructured pluralism which exists in global health today, what is often not fully known is that crowded governance exists within WHO itself. For example, WHO has a Bill & Melinda Gates Foundation-sponsored Health Metrics Network, working alongside a Department of Health Statistics and Informatics; it has a Partnership for Maternal, Newborn and Child Health, and a Department of Maternal, Newborn, Child and Adolescent Health; it has a Tobacco Free Initiative Department and a Secretariat to the Framework Convention on Tobacco Control; there is a Global Health Workforce Alliance and a Department of Human Resources for Health. It is an open secret that there are tensions between these entities, as partnerships and initiatives hosted by the WHO have independent boards and subsequently tend to have more resources This also results in confusion and duplication of efforts at the technical country level. Within the WHO it is well known that the Director-General is not particularly fond of these partnerships and desires to see less of them in the future. The internal crowded governance space constitutes an additional and important dimension to be considered in WHO reform.

Secondly, the governance of WHO is controlled entirely by Member States. As such, other vital players in global health, such as initiatives, philanthropies, the pharmaceutical industry and civil society are unable to take part meaningfully in the decision-making or policy setting processes within the organisation.

Funding and finances

While discussing WHO reform with the Executive Board, the WHO Director-General has stated that 'improvements in financing first require greater clarity about the current and future role of WHO.'[8] It is widely known that WHO is suffering a budget crisis: in 2011 the organisation slashed its annual budget of $US4.5 billion by nearly a quarter and announced plans to cut 300 jobs at the Geneva headquarters.[9] Job cuts and reduction in staff have continued during 2012. The WHO is financed through two streams: Member States pledge a specific proportion of total assessed contributions calculated according to each country's wealth and population; the second stream is through voluntary contributions.

The 'proportional levies' given to WHO by its Member States have not been amended in line with the rising cost of WHO operations.[10] Therefore assessed contributions from Member States have usually equalled approximately 20 percent of the WHO budget. There has been concern as to which Member States will continue to fund the organisation; since the recent global recession, many traditional donors, such as the OECD and European States, have had to scale back commitments. Participants at the informal consultation convened by the Director-General in January 2010 stated that convincing their public and parliaments of the need to increase funding to the WHO was 'hard to sell'.[11] Therefore many have hoped that the relatively economically stable BRIC countries would step up their commitments.[12] However the emerging economies of Brazil, Russia, India and China remain predominantly recipient countries, evidenced by examining the Global Fund: Brazil has received $45 million in grants and only contributed $200,000 to the fund; Russia has received $354 million and donated $254 million; India has received $1.1 billion and only donated $10 million; while China has received $2 billion and donated $16 million.[13] It is important to note that although China, India and Brazil are strong emerging economies, they are countries with great poverty and inequality and remain relatively poor in per capita terms. Therefore it is unclear if they will take on additional responsibilities and increase WHO funding. However there are certainly encouraging signs that they will. The BRICS Health Ministers' Meeting released a Beijing Declaration in July 2011, in which they declared their commitment to support and undertake inclusive global public health cooperation projects.[14] Over an approximately ten-year period (2002 compared to 2012-13) China's, Brazil's and India's contributions (as a percentage of total budget) has increased from 1.0%, 1.4% and 0.3% in 2002[15] to 3.2%, 1.6% and 0.53% respectively in 2012-13.[16]

Due to financial issues within the traditional Member State donors to WHO, the organisation has relied increasingly on voluntary donations. In 2008-2009, 73 percent of WHO's budget was from voluntary contributions and this percentage is rising each year.[17] Further compounding the resource shortage issue is that donors heavily earmark donations for particular causes, which results in skewed global health priorities and a misalignment between financing and the disease burdens of most Member States. In 2008-2009, the WHO's extra budgetary funding was primarily for infectious diseases

(60 percent) and had negligible allocations for non-communicable diseases (3.9 percent) and injuries (3.4 percent). Yet non-communicable diseases account for 62% of all deaths worldwide and injuries account for 17 percent of the global burden of disease.[18] The increasing financial assistance provided by particular private foundations, such as the Gates Foundation, also raises some significant questions regarding the influence that the Foundation exerts over WHO's priority setting. The Director-General has proposed broadening the base for flexible, unearmarked funding by attracting new donors such as foundations, emerging economies and the private sector.[19]

A further WHO funding issue emerges from the fact that the WHO does not practice currency hedging. Revenue to the WHO is received in US dollars, while operations are paid in Swiss francs. Between 2000 and 2010 there was a 34 percent erosion in the weighted purchasing power of the US dollar for the Organisation's payroll costs.[20] It is positive to see that the WHO is revisiting fundamental financing issues, which would include the currency of assessment, as part of its reform process.[21]

Decentralised structure

The WHO consists of headquarters in Geneva, Switzerland and six regional offices scattered worldwide. The WHO Constitution states that the regional offices are to adopt their own rules of procedure and the relevant regional committees should appoint their Regional Director.[22] The Constitution states that the function of the regional committee is to formulate policies, call technical conferences, cooperate with respective regional committees of the United Nations and tender advice to the WHO Director-General.[23] However the regional offices have independently expanded their functions; there is no longer a top-down leadership structure whereby the regional offices support and provide advice to the Geneva headquarters. Instead the Organisation operates more akin to a federation or partnership. The World Health Assembly and Executive Board formally approve decisions but in practice do not provide tight policy and budgetary control over the regions.[24]

The Regional Directors exert so much independent authority without consultation with the headquarters, that their messages can conflict and compete with the headquarters and complicate policy coordination and priority setting. For example, the South East Asian Regional Office (SEARO) issued avian flu treatment guidelines in 2007-8 that were inconsistent with those issued by WHO headquarters. Furthermore, the Pan American Health Organisation (PAHO) announced a global health technology initiative with the United Nations Development Programme (UNDP), a broad mission that arguably ought to have originated in Geneva.[25] The Regional Directors are also politically elected independently of the Director-General's election and consequently they do not work as a collective political entity. The Director General has no direct influence and/or say on the election of the Regional Directors. In 2010 three of the six regional offices informed the Director-General they would not be supporting her re-election in 2012 and as such the Director-General was required to campaign within these regions.[26] To operate effectively, the WHO must be one entity espousing the same mission and priorities.

Difficulties in hiring key experts

The UN personnel system uses a quota system to ensure language and geographic balance. While diversity of employees is certainly a strength, the system requirements and procedures can delay the hiring of key experts and thus skew expertise. Within the WHO itself, administrative tasks have become more complicated as the administrative centre of the organisation has been transferred to Kuala Lumpur in Malaysia. Consequently simple administrative tasks like booking flights have become complex – not only is there a time difference between the two offices, but it is difficult to speak to someone face-to-face if required. Sufficient funding to hire experts is also necessary. A grant provided by the Canadian government enabled the WHO to employ a strong cohort of HIV/AIDS technical advisors for the AIDS '3 by 5' campaign. However this grant recently 'dried up' and competent WHO employees are leaving.[27] The current staffing structure of the WHO, along with the fact that the organisation is hamstrung by its donors tied funding, makes the hiring of experts and the performance of administrative tasks overly complex.

Lack of accountability

The United Kingdom Department for International Development (UK DFID) published a report last year that analysed and critiqued multilateral aid organisations to help decide to which organisations its Government should allocate funding to ensure maximum value of their aid budget. While the report identified WHO's comparative advantage as its authority to lead and coordinate others, it was ranked overall as 'weak' on organisational strengths. Listed weaknesses included: there is no clear and transparent system to allocate aid; there is little evidence that WHO curtails poorly performed projects; WHO has no formal disclosure policy and does not publish adequate specific programme or project details; and targets for savings on administration costs are not stretching.[28] It is important to note, however, that of the 20 UN agencies and programmes analysed, only five were ranked either 'satisfactory' or 'strong' in the 'organisational strengths' section; the rest, including the WHO, were either 'weak' or 'unsatisfactory'. Both GAVI and the Global Fund were rated as 'strong' in both the 'organisational strengths' and 'contribution to UK development objectives' sections. Both GAVI and the Global Fund were also considered to demonstrate strong and inclusive governance systems.

WHY IS THE WHO IMPORTANT?

As there are so many internal and external issues facing the WHO, why is it not simply dissolved and its resources and staff directed to the various other global health agencies? If the WHO did not exist, a similar entity would have to be created.[29] Due to globalisation, urbanisation and increased international travel and trade, coordinated 'global health' is more relevant than ever. WHO Director-General Dr. Margaret Chan has stated, 'In our mobile, interdependent and interconnected world, threats arising from emerging and epidemic-prone diseases affect all countries. They reinforce our need for shared responsibility and collective action in the face of universal vulnerability…'[30]

WHO as the coordinating authority to set normative standards

As the majority of health risks are oblivious to State borders and national policies, it is vital that multilateral action is effectively coordinated. As argued by Pang and Garrett: 'Governance and the setting of normative standards cannot be accomplished with a slew of loosely connected health initiatives, non-governmental organisations and bilateral programmes. The only entity with a character, legislative body and a mandate to fill that role is the WHO and it must do so decisively.'[31]

While recognising that the WHO is 'not perfect', the US Institute of Medicine (IOM) stated in 2009 that the WHO was the only health organisation with the capacity to lead the proliferation of new participants in global health through its mandate for setting evidence-based norms on health-related technical and policy matters.[32] The IOM committee urges the US government to support WHO as a leader in global health by paying its fair share of the organisation's budget and providing technical expertise to WHO. Concurrently, it advises the US government to request a rigorous external review of the WHO. After analysing various global initiatives, the UK Government also recognises that the WHO is critical to the achievement of the health Millennium Development Goals and UK priorities on reproductive, maternal and newborn health and malaria.[33] The emerging BRICS economies also recognise WHO's relevance: 'In our view, WHO has a major role to play in the promotion of access to medication, technology transfer and capacity building with a view to bring more equity to the health sector worldwide.'[34]

Not only are the Member States recognising the relevance of WHO, but civil society is also. Oxfam has urged the protection of the core functions of WHO in its reform process, after physicians in Pakistan reported unexpected deaths at a public health facility serving mainly poor patients for free.[35] It was revealed that the cause of these deaths was isosorbide capsules that were filled in error with antimalarial pyrimethamine. This was due to a breakdown of goods manufacturing practices in Pakistan where there is no federal drug regulatory authority. Kamal-Yanni and Saunders contend that WHO uniquely has the global remit and constitutional mandate to undertake the task of supporting national drug regulatory authority via policy and norms setting and it should continue to do so.[36]

WHO is fundamental to the facilitation of dialogue on health priorities among Member States and the setting of normative standards, relevant to both Member States and other health initiatives. In the immediate future, its leadership on universal health coverage, which will be tabled at the UN General Assembly in 2013, will be particularly crucial. It should utilise its convening power, neutrality, technical capacity and political legitimacy to implement its authority to lead and coordinate others.

Capacity to enact legally binding agreements

Through the WHO Constitution, the World Health Assembly has the authority to adopt conventions, agreements and regulations with respect to matters of public health.[37] As there are so many global health actors, governance has become disjointed and uncoordinated. WHO-created frameworks on ethical research and practices, priority setting, coordination and burden sharing would be welcomed. These frameworks are negotiated and agreed upon by all 193 WHO Member States and so collective action can generally be ensured. The International Health Regulations (IHR) and the Framework Convention on Tobacco Control (FCTC) are two successful international law treaties

that have already been enacted and effectively implemented. The IHR has resulted in an effective global network of surveillance and response as well as building critical capacities in countries to respond to pandemic threats. The FCTC has made important progress in tobacco control worldwide, including the recent passing of legislation to enforce plain packaging for cigarettes in Australia.

Emphasis is returning to multilateral institutions

In the past decades, governments have worked to avert negotiations in cumbersome multilateral institutions such as the WHO and instead have preferred to utilise the more informal and nimble bilateral programmes and public-private partnerships. However the rise of the Global South is transforming global governance.[38] Emerging economies such as the BRICS countries (Brazil, Russia, India, China, South Africa) are more state-centric and sovereignty-guarding in their international relations and the BRICS countries will soon be joined by the MIST countries (Mexico, Indonesia, South Korea, Turkey) as a coalition of significant emerging economies. Subsequently, they are more inclined to utilise formal multilateral institutions that respect the process of government at the national level. Nonetheless it should be noted that bilateral negotiations still occur at the World Health Assembly, with power trades being arranged informally before the formal multilateral decision-making at the Assembly, undeniably undermining the process.

While emphasis is returning to multilateral institutions, there is fear that post-2015 with the end of the Millennium Development Goals (MDGs) and post Rio+20, health is being perceived as receiving less visibility and less priority. The first draft of the Rio+20 document *The Future We Want* disappointingly sidelined the importance of health, although in the final version health was better reflected.[39] Therefore the role of the WHO as a global health champion is, arguably, even more important.

WHAT REFORMS HAVE ALREADY BEEN PROPOSED AND ARE THEY ACHIEVABLE?

The WHO Executive Board and World Health Assembly have held various sessions on the topic of WHO reform. If WHO can establish high level Commissions for Macroeconomics and Health; Intellectual Property Rights, Innovation & Public Health; Social Determinants of Health and most recently, the Commission on Information and Accountability for Women's and Children's Health, among others, why could it not convene an independent commission to look into its own *raison d'etre*? What about the USA's call for an independent review of the WHO alluded to earlier? Instead of a transparent, objective, knowledge-driven and evidence-informed reform process, what has been put in place is a largely inward-looking, almost incestuous, political process akin to a company's board of directors (i.e. the Member States) doing an audit of their own shop (i.e. the WHO). So far it appears to have progressed with the predictable predilection towards 'business as usual' and 'not rocking the boat'.

The external literature abounds with excellent analysis and novel ideas on WHO reform. This section of the paper explores some of the proposed solutions to effectively reform the WHO and considers their feasibility and likelihood of success.

Calls for a more inclusive governance

The general sentiment around WHO reform is that, of the three components being considered in the reform process, (programs/priorities, governance and management), governance is the more problematic and therefore will be discussed at a later stage. Not only is the WHO 'putting its head in the sand', but the cart is being put before the horse, as, arguably, it is necessary to change governance before any meaningful reforms can be enacted. Despite no lack of interest and commitment by WHO to discuss the issues on the reform agenda, governance, the central issue, is not being sufficiently addressed.
There have been calls for a more inclusive governance structure and mechanism that recognises the non-state actors that have become major stakeholders in global health. In contrast to the WHO, representatives from civil society, the private sector and foundations sit on the boards of the Global Fund and the GAVI Alliance.[40] Both of these organisations however are not a part of the UN system and therefore they do not have the added layer of political complexity when engaging with non-state actors. UN agencies such as the Joint UN Programme on HIV/AIDS engage civil society through advisory committees. Proposals to achieve this have included a 'global health forum' or a 'Committee C' of the World Health Assembly.[41] Such a Committee would also serve to increase the accountability and transparency of WHO's decision making processes.
However, this is unlikely to happen as has been explicitly stated by a senior WHO official:

> *"Although the Board asked the secretariat to develop more detailed proposals on how WHO can help bring about greater coherence among all these actors" and "while it is important to hear the views of all players involved in global health", "the Board was clear that the intergovernmental nature of the decision making must remain paramount".*[42]

This is a most telling statement and suggests that such a fundamental and radical change towards more inclusiveness is not going to happen short of a total review of WHO's Constitution and, more broadly, of the post-World War II international order, including the Bretton Woods system, the establishment of the United Nations itself and that of its specialised agencies.
The 65th World Health Assembly requested that the Director-General present a draft policy paper on WHO's engagement with non-governmental organisations (NGOs) to the Executive Board at its 132nd session in January 2013. Interestingly while making this request, the World Health Assembly stressed that the Director-General should be guided by the principle that the intergovernmental nature of WHO's decision-making remains paramount. Consultation for this paper has commenced, which included a consultation with NGOs in October 2012 that proposed a new three-pronged policy, which would foster collaboration, enhance consultation and enable participation in WHO governing bodies through accreditation.[43] How this is going to be enacted or what this policy will look like is yet to be revealed.
Interestingly, opposition to a more inclusive governance mechanism has been voiced not just by the WHO Member States but also by other stakeholders (such as civil society organisations) who fear that well-resourced stakeholders, such as industry and large philanthropies will exert undue influence on the organisation. Although a more inclusive governance system has been proposed, it appears that such radical reform is unlikely to occur.

Reform to the weight of Member State votes

Currently the World Health Organisation operates on a 'one-vote, one-State' voting system. It has been argued that WHO reform should include reform to the voting system, whereby votes become weighted according to financial contributions, such as the system in place at the World Bank.[44] Some developed countries have argued that the one-vote one-state system upsets the balance of power in favour of the south.[45] However it is very unlikely that such a reform would occur, as WHO's coordinating role as an organisation of the world's nation states, where the opinions of even the poorest and smallest nations are heard, would be undermined. Surely if such a reform were to take place, poorer Member States and emerging economies would no longer play an active role in the WHO, the only body with the capacity to assemble the majority of states worldwide on an equal footing.

Reign in the regional offices

There have been some interesting and plausible proposals put forward to reform the decentralised structure of the WHO. Sridhar and Gostin argue that the WHO headquarters should exercise more oversight and control over regional personnel and decision-making.[46] Or, if decentralised decision-making remains the norm, the WHO should apply the same yardstick across regions to assess efficiency and effectiveness. Minimally, the agency should fully disclose the funds within each regional office and how regions meet health objectives, with monitoring and benchmarks of success.[47] Jack Chow has called for the WHO to transition to a system of regional coordinators appointed by Geneva and for the Director-General to have a discretionary fund to implement programs rapidly in response to an emergency.[48] As a result the Director-General would not have to waste time conducting a fundraising tour, which is what Margaret Chan was forced to do in the first few weeks of the H1N1 outbreak. However, given the largely political nature of the election of Regional Directors and the strong vested interests of the various regions, reform in this area is unlikely to happen any time soon despite the perhaps (false) perception that this is largely an internal, administrative matter and should thus be achievable.

Increase WHO's ability to access scientific expertise

As already mentioned, due to the WHO's hiring of personnel system, the capacity to quickly hire necessary key experts is complicated and lethargic. Jack Chow, former Assistant Director-General of the World Health Organisation on HIV/AIDS, Tuberculosis and Malaria, has recommended that an independent global institute of medicine be established, apart from the WHO and apart from the UN personnel system, which has the freedom to recruit and retain scientific staff (which would be analogous to the American Institute of Medicine and the American Senior Biomedical Research Service.)[49] This proposal is perhaps parallel to the Advisory Committee on Health Research (ACHR), which is the highest-level scientific body that advises the Director-General and has counterparts in each of the WHO regions. Rather than recreate the wheel, perhaps it is conceivable that such an institute, as proposed by Chow, could be

reformed and embodied within the ACHR. Greater independence from the WHO itself would be a necessary initial step in its reform process.

FEASIBLE AND ACHIEVABLE WHO REFORM

Assuming that radical change in governance is not going to occur, how can the WHO make viable and practical reforms to reclaim its future leadership in such a crowded health governance space? Firstly, the WHO must set priorities, redefine its comparative advantage and narrow its focus strategically. The WHO has been trying to conduct both vertical programmes on issues such as AIDS, tuberculosis and malaria while concurrently running horizontal programmes, such as pushing for universal health coverage and improved health systems.[50] The WHO does not have the budget, capacity or means to run all of these programmes successfully. It should focus on a limited set of priorities and realign its resources to support those priorities. WHO leadership also needs to define its niche and comparative advantage. Many suggestions have been put forward in several recent publications and reports but perhaps WHO can regain its leadership by focusing on three strategies:

Knowledge broker and coordinator

WHO should function primarily as a knowledge broker of quality information and evidence. As argued by Jack Chow, perhaps WHO should return to its original intention of it being a 'health consultancy to developing countries, supplying advice, analyses and best practices, though stopping short of directly implementing health programmes.'[51] The WHO should access, synthesise and disseminate information and evidence; it should build countries' capacity for developing evidence-informed guidelines and policies; it should use the information to define norms and standards (e.g. ICD, health information) and it should regulate quality (e.g. the DOTs, health domain in ICANN). Global health policies are only as good as the evidence and information on which they are based. The WHO should be the place where the best science and scientists can be brought together for public health advancement.[52] Furthermore, WHO should work at an overarching global level, as opposed to a country level. There are so many health initiatives that are experiencing difficulty in 'managing up' and so coordinating these entities is a unique role that WHO could fulfil.[53]

Create legally binding international agreements

Through its constitution, the WHO has extraordinary rule-making powers to create legally binding international agreements and frameworks. However, the WHO has only promulgated two major treaties in more than 60 years: the International Health Regulations and the Framework Convention on Tobacco Control. WHO has a unique capacity to convene negotiations, which result in legally binding international agreements, and it should seize this opportunity to take a more active role in regulating the world's health. Furthermore, it should play an effective role in monitoring and evaluating their implementation. With so many actors, global health is currently fragmented and so the WHO could offer leadership by setting clear priorities, facilitating coherence and ensuring fair burden-sharing among states. WHO has the exclusive

authority to exert normative power through innovative treaties or through soft power, including codes of practice and guidelines, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel and the Pandemic Influenza Preparedness Framework. Further WHO agreements and frameworks coordinating the actors in global health could result in a more cohesive, coordinated and effective global health governance framework. Agreements currently being informally discussed include a Global Convention on Research and Development and a Framework Convention on Global Health, although this is less advanced and more complex. Other areas the WHO could regulate include counterfeit medicines, alcoholic beverages, food safety and nutrition.[54]

Shift supportive functions to regions

WHO should strategically shift its supportive functions to regions, while the headquarters should focus on core functions. Jamison, Frenk and Knaul propose that headquarters should focus on core functions (which transcend the sovereignty of any one nation state, such as research and development, surveillance and response to epidemics, international legal instruments) while regions (and countries, together with other agencies on the ground) should focus on supportive functions (such as problems within countries requiring collective action at international level due to weak health systems).[55] Such a structural change would allow a rational division of labor and responsibilities and minimize duplication and confusion. Regions and countries could focus on providing strong technical and programmatic support to countries in various aspects of health and health service delivery while headquarters would provide the norms and standards and best practices/guidelines which would guide effective implementation of the overall WHO mission.

The three strategies proposed above must, in turn, be founded upon improved governance, better transparency and accountability in decision-making and more sustainable and predictable financing. Ways to achieve such reforms, such as a Committee C of the World Health Assembly and unrestricted funding from more diverse sources, including the private sector, have been alluded to previously.

CONCLUSION

"The WHO cannot do everything and to be of value, must do what it does do to the highest possible standards."[56] There is currently a leadership vacuum in the global health governance landscape and the WHO is an organisation with great potential to fulfil the role as the leader and coordinator of global health. Currently however, it is facing so many external and internal issues in a more constrained financial reality that it is at risk of becoming redundant, obsolete and irrelevant. To regain its relevance in the global health governance landscape, WHO must reclaim its role as the coordinating authority and knowledge broker of quality information and evidence. It should use its unique normative power to enact legally binding agreements that regulate global health and ensure its effectiveness and it should shift its supportive functions to regions to ensure the greatest use of available resources. Only then will the WHO be able to salvage its leadership role in global health.

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