What is the role of the world health organisation in the new global health architecture?

The last fifty years have seen remarkable, unprecedented successes in the field of global health. Incredible achievements have been made; smallpox has been eradicated while polio and guinea worm are ever closer, widespread childhood vaccination programmes are in place with continually increasing coverage and we have seen life expectancy in low and middle income countries grow at a rate of five years every decade for the past forty years.(1) These historical successes have been largely attributed to the World Health Organisation (WHO); the United Nations' governing body for health. In the past this organisation held a prominent, leadership position within the field of global health, but a combination of lost faith in the organisation and the emergence of a multitude of new actors on the scene has led to a decrease in the influence and power of the WHO.(2) Within today's complex picture of competing public and private organisations, duplications and inefficiencies in the field are undoubtedly highlighting a need for better governance.(3) In the current economic climate we cannot afford to be inefficient in our use of resources, and the multitude of unregulated, independent actors on the scene begs the need for accountability. Should these governing responsibilities be shouldered by the WHO or should they remain as just one of the many actors that make up this complex architecture?

In tackling this subject we must first look at the nature of this so-called 'architecture'. The question itself approaches the topic with the assumption that 'global health architecture' actually exists. The term architecture may be defined as 'the complex or carefully designed structure of something.'(4) It is hard to see design or structure in the disarray of actors that make up the 'architecture' of global health today. Indeed, the Dean of Harvard University's School of Public Health Barry Bloom says that the main problem with global health today is that "there's no architecture of global health."(5) For argument's sake we will take global health architecture to be the "institutions, organisations and cooperation and decision-making structures that link different stake holders together in a more or less established relationship with the health of the world population as their main goal."(6)

The WHO was founded by the United Nations in 1948, with the primary purpose of acting as the 'directing and coordinating authority on international health work.'(7) Even at this stage there were many non-state organisations on the scene; the Red Cross, Medical Associations and various philanthropic and missionary organisations were well-established, and an integral part of the WHO's function was to coordinate these actors. This resulted in existing health organisations becoming regional offices for the WHO.(2) The global health arena functioned in this manner with the WHO as its unrivalled leader until the mid 1970s, when new attitudes towards global health started emerging. International attention towards health boomed, attributed to a number of factors including the realisation that improved health leads to improved economy (5), the increased awareness of global health inequalities raised initially by AIDS activist groups(5) and global pandemics such as SARS highlighting that health risks of one country can quickly become global concerns.(8) These factors, among others, have led to a huge influx of new actors on the scene, many of which have been powerful enough to compete with the WHO in terms of the funding they receive and the power this gives them.

Initially the UN agencies were the major players, the WHO, the United Children's Fund (UNICEF) and following the AIDS pandemic, UNAIDS. The World Bank emerged and by the 1990s its health loans to low and middle income countries had exceeded WHO budgets.(18) Philanthropic donors soon became key

players; the most prominent being the Gates Foundation, who singlehandedly donate approximately as much to global health each year as the total WHO budget. [5] The private sector, in particular the pharmaceutical industry has played an increasing role in global health. This has often been in the form of public-private partnerships such as the Global Alliance for Vaccines and Immunization (GAVI); partnerships between governments and philanthropic donors or industries, many of which completely bypass the UN agencies.[5] Civil society has played an increasing role, with a multitude of NGOs and advocacy groups having a growing voice in the field of global health.

So where does the WHO fit with the rest of these actors? We most certainly have a very different picture now to that of 50 years ago, when all organisations were under the coordination and direction of the WHO. We must beg the question; why has the WHO been sidelined, why has it lost its previous authority? One of the main reasons for this is a profound loss of faith in the organisation. Two past failures of the WHO that they have been heavily criticised for are the failed Malaria Eradication Programme that was abandoned in 1972[9] and the perceived inability of the organisation to cope with the HIV/AIDS pandemic. In the light of the already existing WHO initiatives dedicated to the control of AIDS, malaria and TB, one can only assume that the primary reason for the creation of the Global Fund was that people simply did not believe that the UN agencies had these diseases under control.[10] The second major reason for the fall in power of the WHO is that many of the new actors on the scene have financial and therefore political power that competes with that of the WHO. The last decade has seen funding from bilateral donors, new global partnerships and foundations significantly increase, whilst funding from UN agencies such as WHO has remained fairly constant; [8] the percentage of global health funding available to the WHO is proportionately decreasing. This means that the WHO has less and less influence in the global health community in terms of how and where money should be spent.

One of the main problems with the current situation is that the vast majority of the new actors are focussed towards vertical or disease-specific programmes.[11] Arguably, these initiatives are the primary reason that global health receives the huge amount of funding it does today; they have created global publicity and encouraged many private and state donors to give generously to global health. These initiatives are extremely attractive politically as they are very results-based; they heavily publicise their figures of success, making them a popular option for donors and politicians as they know they are getting their money's worth. However, in recent years, many problems with vertical programs have come to light. Giving millions of dollars with an 'AIDS' or other disease label attached forces developing country governments to prioritise their resources towards these diseases, even though they may not be the most important health threats to the country. These programs are often highly demanding in terms of human resources; their high salaries draw health care workers out of national health systems, leaving them increasingly understaffed.[12] Ministries for health are forced to spend much of their time coordinating different organisations and filling out paperwork, leaving them little time to actually run their health system.[5]These factors have lead to the fragmentation of health systems, with fewer and fewer resources left for investing in primary care and the development of sustainable, comprehensive health services for the population.[12]

Vertical programmes are particularly a problem in light of the increasing burden of non-communicable diseases (NCDs) in low and middle income countries. As heart disease, diabetes and respiratory disease account for an increasing proportion of global morbidity and mortality, primary care is ever-more important and developing countries are in dire need of aid that will contribute to strengthening their health systems, not destroying them. If something in the architecture doesn't change soon, it seems the only way these diseases will receive the attention they need will be the creation of new NCD vertical programmes. However, more disease-specific programmes will inevitably lead to further fragmentation; surely there is a

way of coordinating all these efforts and working with countries' own resources to develop health systems that meet these needs simultaneously?

Another major issue of the global health set-up today is the sheer number of organisations on the scene; from the dominant figures to the smallest of NGOs, the landscape is littered with organisations that compete for funding and the best results, and that we have no regulation over. For example, a recent paper estimated 60,000 organisations devoted solely to AIDS.[2] This no doubt leads to duplications and inefficiencies, as people are attempting to carry out similar objectives simultaneously, but without communicating or attempting to coordinate their efforts. Even more importantly, there is the issue of accountability. There has been a recent call for NGOs and other organisations to be more transparent in their actions and use of funding, but there are no formal mechanisms in place to ensure that NGOs are using funds responsibly for sustainable projects and are not causing any harm to countries in their attempts to 'do good'.[13] Many of these issues apply even to the big players; whilst these organisations tend to be more transparent, sustainability is still a key issue - we have seen in the last year how actors such as the Global Fund are not immune to sudden cuts in funding.

I have highlighted several of the problems with the global health architecture today, and I believe they all cry out for better governance. Many authors agree that a change in global health governance is a vital step we must take if we are to continue to progress in this field.[2,10,11] I firmly believe that the WHO holds the answer to many of these problems. Decision-making and agenda-setting in global health should not be the role of Western-dominated organisations; global health governance should happen in a place where every country has an equal say, a phenomenon that we only see within the UN. Additionally, if we are to progress in health systems strengthening as a key area of the next chapter in global health, who better to lead us than the WHO, who has long-established relationships with health ministries and has already declared this as their priority.

The WHO defines its role in global health as carrying out these six core functions:

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed
2. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge
3. Setting norms and standards and promoting and monitoring their implementation
4. Articulating ethical and evidence-based policy options
5. Providing technical support, catalysing change, and building sustainable institutional capacity
6. Monitoring the health situation and assessing health trends [14]

The WHO has repeatedly been both praised and criticised for the way it has carried out these different roles. The organisation has always been particularly strong in monitoring health trends – it remains the primary provider of information and statistics about the state of the world's health[15] and is also one of the leading providers of health policy. Due to word constraints I will only explore in detail the WHO's role in "providing leadership on matters critical to health."

In 2010, Margaret Chan publicly recognised that it was unrealistic for the WHO to "aim to direct and coordinate all of the activities and policies in multiple sectors that influence public health today." [16] The WHO simply does not have the resources to function as a leader with directing authority over the other actors in the way that it did when the organisation was first created. How then, can it exercise a leadership role? Various new methods of health governance have been proposed and some trialled.

Firstly, a place where the WHO is part of a global decision-making board, but not necessarily at the head of it, is the H8. This is a group of the eight most prominent actors in global health, including the WHO, the

Global Fund and various others, who met together for the first time in 2008.[12] This is a step in the right direction in that it has got the key actors communicating, the first step towards coordination of efforts, and it is a place where the WHO can influence the other major actors. However, as a group of actors they are dominated by a Western way of thinking as most of the representatives come from Western-dominated organisations.

Kickbusch et al suggested that in attempting to have more of an influence on global health agenda, the WHO should instead focus its efforts on setting international norms and standards that states and other organisations would have to abide with. They propose the creation of a third committee at the World Health assembly, 'Committee C', in which all major actors would be able to attend and have their say, but the only members of the WHA would be able to vote.[2] This appears to be the best of both worlds; all major actors would be involved enough in the governance process for it to influence their actions, but the final decisions would be made by equal representation from all member states, thereby ideally removing any Western bias.

Margaret Chan has proposed that the way forward for the WHO is to reform in terms of how it carries out its governance role; she has suggested the formation of a World Health Forum (WHF). This is similar to 'Committee C' in that it would bring together member states with all the other major actors.[17] This would almost certainly achieve greater cohesion in the global health architecture, but fears over how it would interfere with WHO governance and priority setting has meant that this proposal has been less popular among member states than anticipated. Particular concerns have been over increasing private sector influence over the WHO, however, with the increasing influence of the private sector in the wider global health community this may be the lesser of two evils; if the voice of the private sector can be harnessed under an overarching WHO-run forum where member states have the final say, surely this is a positive move?

Finally, it must not be overlooked that "providing leadership in matters critical to health" is not exclusively confined to influence within the health sector. The WHO has had successful influence in advocating for health in other sectors; the WHO Framework Convention on Tobacco Control serves as a good example of this. In the future there is much need for heath advocacy in other sectors; in particular with respect to the emerging threats from climate change.

We are in a place where unprecedented amounts of funding and attention are being focussed towards global health. We have the resources to make a huge impact on the massive health inequalities around the world, but this will only be possible through strong leadership from the WHO and a coordinated effort from all parties to work together towards common goals.

References

1. Jamison DT (2006) Investing in Health. In: Jamison DT, Breman JG, Measham AR, Alleyne G, Claeson M, et al, eds. Disease Control Priorities in Developing Countries. Washington DC: World Bank pp 3-34.

2. Kickbusch I, Hein W, Silberschmidt G Addressing global health governance challenges through a new mechanism: The proposal for a Committee C of the World Health Assembly Journal of Law, Medicine and Ethics 2010; 550-563

3. Szlezak NA, Bloom BR, Jamison DT, Gerald TK, Michaud CM, Moon S, Clark WC The global health system: Actors, norms and expectations in transition PloS 2010 7; 1: 1-4

4. Oxford dictionaries Available online at: http://oxforddictionaries.com/definition/architecture [Accessed on 30/1/2012]

5. Cohen J The New World of Global Health Science 2006 311 (5758): 162-167

6. Fidler DP. Architecture amidst anarchy: global health's quest for governance. Global Health Governance 2007; 1: 1-17

7. WHO The World Health Organisation Constitution 1946

8. The World Bank: The New Global Health Architecture 2007 Annex 1

9. Greenwood BM, Fidock DA, Kyle DE, Kappe SHI, Alonso PL, Collins FH, Duffy PE Malaria: progress, perils, and prospects for eradication The Journal of Clinical Investigation 2008; 118, 4: 1266-1276

10. Yamey Why does the world still need WHO? 2002; 325 pp 1294-1298

11. Ollila E Global health priorities – priorities of the wealthy? Globalisation and Health 2005; 1:6

12. Takemi K and Reich MR The G8 and Global Health: Emerging architecture from the Toyako Summit

13. Doyle C and Patel P Civil society organisations and global health initiatives: Problems of legitimacy. Social Science and Medicine 2008; 66: 1928-1938

14. WHO The role of the WHO in Public Health 2006 Geneva Switzerland

15. Rugar JP and Yach D The global role of the World Health Organisation Global Health Governance 2008 2; 2: 1-11

16. Chan M "The future of financing for WHO" 2010, Geneva Switzerland

17. Doble R Reforms for a healthy future? WHO in critical negotiations. A Global village 2011 5; 6-9