



GLOBAL HEALTH CENTRE WORKING PAPER NO. 24 | 2020

# THE GLOBAL HEALTH WE NEED, THE WHO WE DESERVE

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## Abbreviations

CBD	Convention on Biological Diversity
CITES	Convention on International Trade in Endangered Species of Wild Fauna and Flora
COVID-19	Coronavirus Disease 2019
FENSA	Framework of Engagement with Non-State Actors
GHSA	Global Health Security Agenda
H1N1	Hemagglutinin 1 and Neuraminidase 1
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IAEA	International Atomic Energy Agency
IHME	Institute for Health Metrics and Evaluation
IHR	International Health Regulations
IPBES	Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services
IPCC	Intergovernmental Panel on Climate Change
MERS-CoV	Middle East Respiratory Syndrome-related Coronavirus
NGO	Non-Governmental Organisations
OECD	Organisation for Economic Co-operation and Development
OIE	World Organisation for Animal Health
PPP	Public Private Partnership
RBM	Roll Back Malaria
SARS	Severe Acute Respiratory Syndrome
SDG	Sustainable Development Goals
UN	United Nations
UNEP	United Nations Environment Programme

## Abbreviations

WHA	World Health Assembly
WHO	World Health Organization
WWF	World Wildlife Fund





# EXECUTIVE SUMMARY

During the Covid-19 pandemic, the World Health Organization (WHO) has been blamed for ineffectiveness in response to the global health crisis. Caught in the midst of diplomatic tensions between China and the United States, the organisation has provided a vivid example of the limited capacity of the UN system to carry out its mission of preventing and coordinating responses to major global challenges.

WHO remains little known to the general public, although it carries out important missions to protect people's lives, such as public health surveillance, technical assistance to governments, consensus building and knowledge sharing, international advocacy for universal access to health, and international coordination of responses to global health threats. It plays an even more crucial role for countries with fragile health systems and weak research capacity.

Persistent criticism from governments overly targets WHO's internal management and governance deficiencies. Although there is no reason to exonerate the organisation from internal intricacies, the debate should rather focus on its capacity, legitimacy and authority in global health governance. A significant part of the response to the challenges the organisation faces in coordinating international responses to health crises depends on the will of governments to effectively delegate authority and transfer appropriate resources to the multilateral system. This paper proposes six recommendations for reforming global health governance.

What does WHO need? Greater authority in emergency situations; increased financial autonomy; internal reorganisation to improve efficiency and restore the authority of the director-general; enhanced inclusion of scientific communities; greater involvement of non-state organisations; and closer connection of global health with biodiversity and climate issues.

**1.** In a global health crisis, it is essential to reliably and transparently share information. The lack of cooperation by a single state can lead to large-scale disasters. However, within the limits of its authority, WHO still depends on the goodwill of governments when it has to coordinate a response to a pandemic threat, which carries considerable risks to the security of all. It would benefit from being given enhanced authority to conduct mandatory inspections in countries and alert the international community when a state fails to meet its obligations in addressing a significant public health risk of international concern.

**2.** The freezing of recurrent assessed contributions from Member States has slowly changed WHO's financial structure, which now depends mainly on so-called voluntary contributions, some of which come from the private sector, and which are often earmarked for specific projects. The promotion of health priorities cannot depend solely on such resources, which fluctuate, are unpredictable, and are subject to varying demands from individual major donors. Financial reform should help reduce WHO's dependence on earmarked funding.

**3.** Uniquely among UN organisations, WHO is divided into six regional offices, each with a regional director, a separate budget and staff, and specific priorities. This institutional structure fragments the organisation and, in some instances, reinforces rivalries between its various components to the detriment of the coherence and effectiveness of international operations. Today, it is, therefore, essential to give the Geneva Secretariat, including the director-general of WHO, the capacity to restore leadership within the organisation.

**4.** WHO's role in the production of scientific knowledge needs to be reconsidered as global health research networks expand, multiply and rearrange. International institutions in the fields of climate and biodiversity, such as the IPCC and the IPBES, provide interesting perspectives for the evolution of global health governance. The creation of an "IPCC for global health" would increase the role of scientific communities in the production of global knowledge on health risks. It would set up mechanisms that would enable the scientific community to have a stronger voice in influencing health policy decisions.

**5.** Government agencies are no longer the only leading actors in the field of global health. NGOs, civil society networks, philanthropic organisations, foundations, and private companies have emerged as essential partners in global and national health policies. As an intergovernmental entity, the WHO should thus give a greater place to non-state actors. At the same time, however, it is essential to continue to strengthen safeguards, and prevent attempts by industry actors and some governments to exert undue pressure on WHO standard-setting activities.

**6.** The 2020 pandemic has raised awareness of the impact of environmental degradation on human health. The “One Health” approach illustrates the need to better address interdependencies between human health, animal health, and environmental health. For example, biodiversity conservation, farming and agricultural development, food security, and global warming mitigation, which are currently handled by different institutions, should now be systematically combined and tackled through comprehensive initiatives.

Human health is a shared public good. It is, by nature, “global health” – it can neither be protected nor promoted without an international response. To develop such a response, WHO must not be alienated. It must be reinvented.



# 1 | INTRODUCTION

The international crisis triggered by the SARS-CoV-2 virus is a classic example of the predicament of multilateralism. The lack of a coordinated response to the global health emergency in the early months of the outbreak has shown once again the fragility of international cooperation mechanisms. The United Nations (UN) system has remained crippled by rivalries between states: the UN Secretary-General has gone largely unheard by heads of state, the Security Council has been unable to agree on a common resolution on humanitarian issues, and the World Health Organization (WHO) has faced multiple challenges in coordinating the international response amid fragmented government strategies on the health threat.

The health crisis reflects the geopolitical reshaping of the world. It provides a stark illustration of the rise of China, the new Sino-American rivalry, and the unprecedented weakening of the Atlantic alliance that had given Western countries effective control over the UN system since the 1990s. The crisis has also been an accelerator of change. It has reinforced the unilateralist strategy of the United States (US) and given China the opportunity to pursue an increasingly assertive foreign policy combining strategic investment, technical assistance to low-income countries, and acquisition of influential positions in international organisations. It has further weakened the liberal foundations of the UN system built after 1945. In a time when health threats bring new security challenges that national governments cannot address in isolation, the COVID-19 crisis underlines how difficult it is for the multilateral institutions to fulfil their mission of prevention and response to collective risk.



## 2 | THE WORLD HEALTH ORGANIZATION (WHO) UNDER FIRE

Over the last three decades, the role and functioning of WHO have been examined after each global health crisis (HIV/AIDS in 1990–2000, SARS in 2002–2004, H1N1 influenza in 2009–2010, MERS-CoV in 2012, Ebola in 2014–2015, and COVID-19 in 2020). Observers and politicians pointed to gaps and weaknesses in its mission to coordinate international responses to health threats. Even beyond times of crisis, the Geneva-based organisation has repeatedly been accused of ills such as excessive politicisation, competition between departments, bureaucratic slowness, insufficient resources, and exposure to private-sector lobbying. Such accusations have often been made by the organisation's most prominent Member States.

Like any intergovernmental agency, WHO works within the mandate set by Member States, including during crises. It is based on a central legal instrument aimed at giving the United Nations authority to guide policy responses to imminent health threats: the International Health Regulations (IHR). Originating in the 1851 International Sanitary Regulations, the IHR were established in 1951, and revised many times since. They establish rules for international cooperation in the fight against “public health emergencies of international concern”, particularly the spread of infectious diseases. The IHR provide WHO with a mandate for monitoring, early warning, alert, and coordination of health responses. However, in practice the organisation cannot act without the full cooperation of its members, over which it has no coercive power.

To a large extent, WHO's difficulties asserting its leadership in the management of health emergencies reflects a lack of political will on the part of its members, in particular its major donors, which have the power to give it full legitimacy and resources. The organisation makes an ideal culprit in times of crisis: criticism helps states mask their unpreparedness and inertia, along with their desire to maintain health sovereignty at the expense of transnational health concerns.

## 2.1 What is WHO for?

In 2020, critics have pointed at WHO's inability to fulfil its mandate under the IHR. These criticisms are far from unfounded. However, by focusing attention on WHO's role in international health crisis response, they tend to obscure the multiple missions the agency performs within the framework of its 1948 founding Constitution.

First, WHO is responsible for observing and studying the origin and evolution of health risks, which are by no means confined to epidemics of viral origin. More specifically, WHO monitors populations' health status. To this end, it collects, aggregates, compares, and shares data from countries. It studies and lists diseases, major health risk factors in countries, and the health vulnerability of the most fragile social groups. It also reports on scientific and medical advances and disseminates knowledge in the form of comprehensive and accessible policy-oriented information.

Second, WHO performs an important norm-setting activity. Drawing on the latest biomedical research findings, it elaborates official recommendations in the form of international guidelines and standards to which all national health actors can refer (e.g. on health service quality, obesity prevention, alcohol consumption, sex education, or child growth standards).

Third, WHO provides technical assistance to governments in countries with limited resources and fragile health systems. For these countries, the agency operates through knowledge dissemination and training of health professionals. It thus takes part in national health strategy improvement and health capacity development, although it faces competition in this role from other multilateral institutions (such as the World Bank), bilateral aid agencies, consulting firms, and philanthropic organisations.

Fourth, WHO plays an important advocacy role, participating in international campaigns on major public health issues. Since its inception, the organisation has been committed to promoting a vision of global health that focuses on access to healthcare and medicine, human rights protection, and alleviation of health inequality. It is true that its approach to global health has for 30 years sought to combine an ethical conception of health as a common good of humanity - considering health as a non-market good - with the promotion of private sector delivery of public health services in low- and middle-income countries. Nevertheless, WHO is the only intergovernmental agency to have advocated universality and solidarity in health, from the Alma Ata Declaration (1978) on primary healthcare to the promotion of universal health coverage over the decade since 2010. It has repeatedly opposed a view of global health governance as being embedded in the international trade regime – a market-based regime in which intellectual property rights have become a major factor



limiting equal access to quality medicine and health technology. WHO is the main intergovernmental organisation prioritising the needs of populations made vulnerable by poverty, efforts to strengthen health systems in low-income countries, and a focus on diseases neglected by rich-country pharmaceutical companies.

In 1948, WHO was conceived of as a “directing and co-ordinating authority on international health work” that, among other functions, would ensure valid and productive technical cooperation and promote research (Article 2 of its Constitution). Thus, its mission is not to carry out health policies as such. It is not designed to supersede national health authorities. It is not meant to act as an international funder or an operational actor in health policies in low-income countries. In the context of development strategies or humanitarian programmes, bilateral agencies, medical non-government organisations (NGOs), private or public-private initiatives, and hospitals are involved, through cooperation policies, in the operational implementation of health strategies.

Despite limited resources, since its inception WHO has demonstrated its ability to promote health. It has enabled the adoption of key health standards, such as the Framework Convention on Tobacco Control (2003), the Model List of Essential Medicines (1977), the International Classification of Diseases (frequently revised since 1949), and the Report of the Commission on Macroeconomics and Health (2001), aiming to provide evidence on the impact of health on economic development. It has actively encouraged biomedical research and coordinated vaccination campaigns to combat devastating epidemics, with major successes on smallpox and polio, for example. It has contributed to the improvement of healthcare practices, e.g. by supporting community health. It has raised policymakers’ awareness of health priorities neglected by global donors, such as promotion of maternal and child health, the fight against tropical diseases, the need for food standards, and, more recently, management of chronic non-communicable diseases.

WHO has also campaigned, alongside NGOs and advocacy groups, for integration of health into poverty reduction strategies, access by the poor to essential medicine, inclusion of vulnerable populations and patients’ associations in health policy, flexibility and adaptation of health-related patent policy in low-income countries, and better worldwide recognition of mental health. In 1999, it initiated a major review of the impact of environmental factors on health in Europe, opening up discussions on the relationship between human, animal, and environmental health. In 2005, it set up the Commission on Social Determinants of Health to examine the health effects of growing inequality.

## 2.2 WHO under scrutiny in every epidemic

Although the history of global health demonstrates the importance of WHO's achievements, it also shows the limits of multilateralism. For many years, various independent reviews have periodically suggested that the agency is in crisis. Criticism includes lack of leadership by the director-general, weak financial resources, dependence on donors, delays in funding allocation mechanisms, overly bureaucratic management, insufficiently flexible emergency responses, poor coordination of operational interventions during crises, infighting among departments, deficiencies in human resource management, excessive politicisation of World Health Assembly (WHA) discussions despite scientific consensus, and undue pressure from industry and governments on technical personnel.

Internal reforms over the last 30 years show that, prompted by donors, WHO's directors-general have been willing to change the organisation's governance. The criticism particularly crystallised when controversies arose over conflicts of interest on the part of experts involved in standard setting, and intensified at revelations of corporate lobbying or pressure from governments to impede or redirect policy objectives. WHO has had to deal, for example, with highly questionable influencing strategies from tobacco, food, and pharmaceutical companies with regard to the effects of hypertension, essential drugs, and neglected diseases.

Criticism of WHO has also surfaced with each epidemic. In 1994, internal tensions led to revocation of the organisation's responsibility for coordinating the fight against HIV/AIDS. In 2003, during the outbreak of Severe Acute Respiratory Syndrome (SARS), WHO was criticised for delays in launching an international alert due to the Chinese authorities having withheld evidence. During the 2009 H1N1 flu pandemic, the agency was accused of having reacted too hastily in recommending that national authorities buy massive amounts of vaccine, which in the end generated huge profits for the pharmaceutical industry. In 2014, internal divisions and a lack of resources limited WHO's ability to monitor the spread of the Ebola virus in West Africa, causing it to alert the international community far too late.

Each major outbreak was followed by an independent evaluation to draw lessons from the gaps in crisis management and provide input for reforming global health governance. In 2005, the SARS epidemic led to revision of the IHR and strengthening of signatory states' obligations. In 2011, in the aftermath of H1N1, an emergency reserve fund was established, followed in 2014 by an Emergency Response Framework, although these proved ineffective during the Ebola epidemic. That situation resulted in the adoption of a new health crisis management programme, providing WHO with greater operational capacity for emergency response to affected countries, an incident management system, additional funds for emergencies, and more expert staff. These reforms largely

eliminated delay and managerial dysfunction during the COVID-19 episode but could not overcome the political obstacles caused by the Chinese government's attitude during the epidemic's initial phase in and around Wuhan (December 2019 to mid-February 2020), which then affected WHO's monitoring and coordinating role during the expansion phase of the crisis (mid-February to May 2020).

## 2.3 WHO in the new global health landscape

WHO operates in an international environment that has undergone profound change in the last 30 years. Today, multiple platforms and intertwined initiatives for global health are proliferating, such as “vertical funds”, PPPs, bilateral programmes, multilateral initiatives (including the G7), private foundations, international NGOs and transnational advocacy coalitions, universities and clusters of research institutions, consulting firms and alliances of industrial partners. Some implement public health campaigns. Others provide healthcare assistance for low-income countries. Others The international environment is now more fragmented and structured into inter-organisational networks and multi-stakeholder partnerships, with variable geometry and specific objectives.

In this new global health landscape, WHO no longer occupies the central position it did until the 1990s. New entrants have harnessed a significant share of additional public and private resources for health. Major donors to global health do not hesitate to consider using PPPs to implement their programmes, giving private operators and specialised NGOs increasing responsibilities in the development, provision, and delivery of health products, as well as in assistance to national authorities, training of health workers, financial coordination, and the establishment of new partnerships. In some policy areas, the private sector has gained prominence. For instance, it plays a major role in health system financing, drug manufacturing, biomedical research, and health technology production.

In addition, many international partners, including the most powerful states, are increasingly disinclined to consider the WHA the preferred forum for multilateral health diplomacy. Instead, they engage in forum shopping, moving into arenas and partnerships that may seem more appropriate to advance their interests and priorities at any given time. For instance, rich countries engage in “club diplomacy” through the G7 and G20. They practice “minilateralism” to reach agreements on international health objectives rather than entering WHA's discussions with 194 members. Some powerful countries, including the United States, prefer to channel their financial aid to health through their own technical operators or multi-actor initiatives they control. Finally, in global health governance, multilateral institutions have entered the field since the 1990s. The World Bank, for

instances, uses financial, technical, and research resources to wield decisive influence on health policy development in client countries, and the World Trade Organization defines the rules for marketing medicines and health services.

WHO remains a critical player in international standard setting for health. It conducts health advocacy campaigns, provides technical assistance, and coordinates health crisis responses under the 2005 IHR. However, its leadership and coordination capacity have eroded since the 1990s. In 2010, its difficulty responding effectively to the cholera epidemic in Haiti led one of its former deputy directors to ask a burning question: “Has WHO become irrelevant?”.

WHO is the only intergovernmental institution in which all the world’s countries can converge towards common global health objectives. Although market-based approaches to provision of health goods and services are gaining increasing momentum in the international system, WHO continues to promote a vision of health based on the needs of populations, the strengthening of health system and the principle of solidarity among countries. Faced with the prospect of the institution being circumvented, abandoned, or even dismantled, it is time to identify necessary reforms for WHO to fulfil its mission as the lead agency in global health.

### 3 | SIX PROPOSALS FOR GLOBAL HEALTH GOVERNANCE

WHO reform cannot be expected to solve all challenges concerning better global health governance. Much of the response to deficiencies in health multilateralism relies on governments' political will, particularly that of leading global health donors. In every global health crisis since the early 2000s, major WHO members have blamed the organisation for "dysfunctions" and "failures" that they themselves have generated, meanwhile deploring its secretariat's powerlessness in turbulent times. Governments have complained about ineffectiveness in an intergovernmental body they have underfunded and delegitimised for almost three decades, while public resources and diplomatic efforts have been directed to other institutions deemed more effective. The problem is therefore primarily political: restoration of WHO's authority depends on powerful states' ability to appreciate the potential benefits of a multilateral organisation rather than opting for uncoordinated bilateral foreign policy strategies. The staggering economic cost of the COVID-19 crisis could increase donors' awareness of the need to reinvest in international cooperation, although the unilateralist strategy of the Trump administration makes the short-term outlook dim. Against such strategic and geopolitical factors, institutional reforms, however ambitious, can do very little.

Instead, this essay proposes reforms that could restore WHO's leadership in global health governance. These proposals do not focus exclusively on the organisation's internal structure but also address potential changes in the field of global health. Reform of WHO requires it to adapt to a new international environment with ever-changing rules and mechanisms. Let us immediately clear up one ambiguity: the idea here is not to advocate for development of a hydra-like international institution with multiple functions but rather to rebuild WHO's authority in what it does best: generating knowledge and setting standards that promote a universal approach to health for all. It is not WHO's vocation to be a financial player in global health, implement health policy, participate in humanitarian programmes, or even conduct its own research. Other entities – multilateral banks, vertical funds, development agencies, multi-actor partnerships, NGOs, health providers, national research institutes – perform these tasks with greater efficiency. However, WHO can exercise a convening power if Member States work to revitalise the organisation and give it a mission to build a common vision regarding global health challenges.

## What is needed for WHO to fulfil its potential?

1. Strengthened authority in emergency situations.
2. Greater financial autonomy.
3. Internal restructuring aimed at improving efficiency and restoring the legitimacy of the director-general's office.
4. Enhanced inclusion of transnational health research networks in WHO's knowledge production activities.
5. Better participation of non-state organisations in WHO governance.
6. Integration of global health institutions with those concerning biodiversity and climate

### 3.1 Proposal 1: Strengthen the International Health Regulations

Deficiencies in monitoring of the 2003 SARS epidemic due to China's lack of cooperation with the WHO Secretariat led members to revise the IHR in 2005. The revised regulations strengthened members' obligations to track and report emerging health risks arising on their territories. They also gave NGOs the right to provide the organisation with information from the field. In addition, they gave the WHO Secretariat increased coordination responsibilities, including the authority to declare a public health emergency of international concern and to issue instant policy recommendations to Member States. Thereafter, a series of reforms were made in response to deficiencies observed during the crises of 2009 (H1N1), 2012 (MERS) and 2014 (Ebola). Nevertheless, a few months before the COVID-19 outbreak, the 2019 Annual Report on Global Preparedness for Health Emergencies pointed out national health systems' low preparedness and the lack of international resources dedicated to epidemic risks.

As the COVID-19 crisis revealed, WHO's ability to carry out its mandate still depends too much on the good faith of governments – their willingness to share reliable and transparent information, and then, at the onset of the crisis, to host surveillance and control missions under conditions left to their discretion. In cases where WHO does not obtain a national authority's full collaboration, the director-general can only inform other members, "encouraging" the government concerned to "accept the offer of collaboration by WHO, taking into account the views" of that government (IHR, Article 10.4).

The possibility of compelling a state in breach of its obligations to comply is limited in practice, as WHO needs to maintain good relationships with government officials, who may at any time decide to conceal risks, share unreliable data, expel foreign experts, and lock the state into a non-cooperative position. WHO has no power to refer the matter to a supranational authority empowered to issue warnings or adopt sanctions in the event of non-compliance with the IHR. It may be subject to retaliation if it disputes national health authorities' decisions. In April 2020, for example, WHO's resident representative in Burundi was declared *persona non grata* after he warned against holding pre-election rallies during the health crisis. The organisation's coronavirus expert team was later expelled from the country.

The IHR should be revised to ensure that international health emergency response is based on the principle of collective security. Global health issues already fall within the scope of international security, in accordance with several Security Council resolutions on health issues since 2000, in particular with regard to epidemic risks. Consequently, nothing prevents WHO from being granted a mandate comparable to that of the International Atomic Energy Agency (IAEA), one of the very few international organisations with the power to carry out binding inspections aimed at verifying countries' compliance with their international obligations. The IAEA statutes, moreover, include health protection: Article 2 authorises the agency to carry out inspection missions to ensure that effective health regulations protect local populations from nuclear risk. The IAEA may refer to the Security Council any failure by a country to meet its obligations. Threats to populations' health are thus already associated with the international security regime.

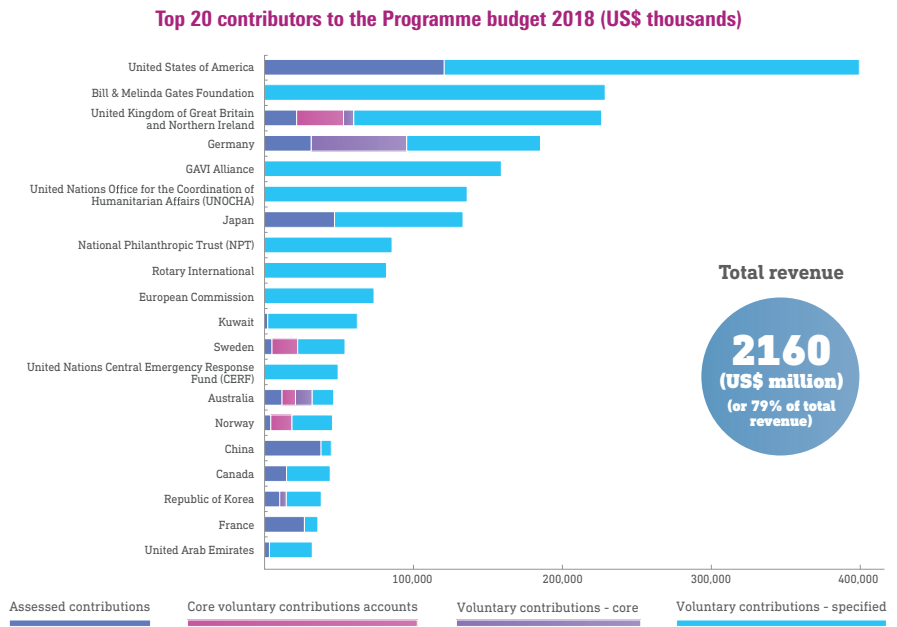
To prevent future pandemics, the IHR should be further revised to increase WHO's authority in line with the IAEA's institutional model: the secretariat and director-general should be empowered with enhanced capacity to detect and assess health risks of international concern, including through in particular through mandatory inspection visits to health facilities located in the centre of a viral outbreak. In the event of a clear breach of the IHR posing a threat to public health, the director-general should be able to refer the matter to the UN General Assembly and/or Security Council to determine the measures necessary to compel the country concerned to fully cooperate.

### **3.2 Proposal 2: Reduce WHO's financial dependence on voluntary contributions**

The financing of WHO has significantly changed since the end of the 20th century. The organisation has experienced budgetary erosion as a result of the zero nominal growth policy that donors have applied since 1993 with regard to "assessed contributions" – the compulsory dues that Member

States pay each year, which contribute to the general programme. Such erosion has been exacerbated by the cumulative effects of the 2008 and 2011 financial crises, the build-up of payment arrears by several members (including the United States), and the reluctance of emerging countries (including China) to increase their financial effort, despite the relative growth of their national wealth.

In recent decades, the stagnation of assessed contributions has been offset by growth in “voluntary contributions” from public and private donors. Most are conditional contributions, earmarked for specific programmes and limited periods. Initially considered supplements to assessed contributions, voluntary contributions have over the years represented an increasing proportion of the programme budget: from around 20% in the 1970s to 50% in 1998–1999 and almost 80% in the 2018–2019 budget. The magnitude of growth in the voluntary share at WHO is unprecedented for a UN agency. It stems not only from the need to compensate for zero growth in the permanent budget but also from the principles of “selectivity” and “value for money”, which international donors have applied to funding of development organisations since the late 1990s: any financial allocation engages the organisation’s accountability, which means it must be tied to specific objectives, be evaluated against results, demonstrate effectiveness, and provide evidence of added value.





Donors find benefits in this shift towards selective contributions: their funding flexibility increases, they select the activities they want to support, and they can require recipients to be more accountable. In terms of image, specified voluntary contributions increase their diplomatic visibility by supporting clearly identifiable health programmes. WHO may also have an interest in such funding, which can allow it to obtain additional support for poorly resourced activities, initiate projects in new areas, and, in some cases, help it circumvent political resistance from certain members.

Nevertheless, the evolution of WHO's budget structure has created constraints for the organisation. First, it affects the stability and predictability of contributions, as donors may suddenly redirect, reduce, or withdraw their funding, disrupting programme continuity. In early 2010, for instance, some countries refused to confirm their voluntary contributions for emergency programmes. The resulting financial cuts severely limited WHO's ability to respond to the Ebola crisis. The director-general at the time, Margaret Chan, noted in 2014: "When there's an event, we have money. Then after that, the money stops coming in, then all the staff you recruited to do the response, you have to terminate their contracts."

Second, the volume of voluntary contributions forces WHO to constantly align its programmes with donors' changing priorities, depending on their areas of interest, sometimes to the detriment of public health issues supported by experts and scientists. For example, for many years WHO has had difficulty promoting prevention of non-communicable diseases, as donor efforts were mainly focused on other priorities, including the fight against viral epidemics.

Third, reliance on voluntary contributions means WHO departments have to devote considerable time and resources to fundraising, and then to compliance with donors' financial oversight requirements, rather than focusing on the core missions of health monitoring, data collection, research analysis, dissemination of information and recommendations, technical assistance, and responses to health crises. Voluntary contributions also lead to harmful competition between departments as each defends its internal priorities. Such funding makes departments more vulnerable to donor influence. It also results in fluctuation of the organisation's priorities from one budget period to the next. Margaret Chan lamented in 2012, "Current financing practices make WHO a resource-based and not a results-based organisation".

Lastly, the most important impact of these international funding modalities is WHO's increasing dependence on contributions from private donors. Given its difficulties sustaining a budget commensurate with its missions, WHO had no alternative but to seek funding from international philanthropic groups (e.g. Gates Foundation, Wellcome Trust, Vital Strategies, Rotary International, Bloomberg Family Foundation, National Philanthropic Trust), public-private alliances (such as GAVI),

and the private sector for smaller contributions (including pharmaceutical companies, such as Bayer, Roche, Gilead, GlaxoSmithKline, and Sanofi Aventis), in addition to alternative public sources such as development finance institutions, the European Union, multilateral organisations, and local or national governments. Financial contributions of non-state actors currently amount to almost half the WHO budget. At US\$ 228 million, the Gates Foundation was the second largest net voluntary contributor in 2018–2019, just behind the United States. Private actors and foundations are also involved through participation in the numerous PPPs WHO has resorted to since Gro Harlem Brundtland's mandate (1998–2003). They also intervene through governing body sessions, consultations, technical collaboration, knowledge exchange and advocacy events organised with WHO staff.

Budget erosion, a higher proportion of voluntary contributions, growing contributions from private donors: in this context of external financial dependence, it is hardly conceivable that WHO could preserve its independence in its scientific and standard-setting activities, and that its departments might not be led, in some cases, to censor themselves in their relations with donors that have become indispensable to their programmes' sustainability. A large number of studies point to private actors' influence on the organisation's strategic choices and, in some areas, heavy reliance on the private sector.

Hence reforms should be aimed at increasing the share of non-earmarked contributions to at least 50% of WHO's budget. This would allow the organisation to initiate long-term programmes without worrying about their sustainability. It would also give it greater flexibility in the use of funds to respond to rapidly changing health challenges. In 2019, the organisation estimated that it had financial flexibility in only one-third of its budget. So-called core voluntary contributions – fully flexible at the programme budget level, very flexible as regards expenditure categories – should be significantly increased from their current share of only 8 per cent of voluntary contributions.

Similarly, WHO needs a new financial strategy to reduce its reliance on earmarked funding. The creation in 2019 of a Partners Forum to develop the organisation's long-term vision is a first step towards this goal. Similarly, the WHO Foundation, established during the COVID-19 crisis (27 May 2020), offers an opportunity to include individuals in the fundraising strategy and to raise additional flexible resources. As an independent entity under Swiss law, its activities will not require WHA approval, so it could allow the organisation to fund emergency operations or activities on neglected health issues.

### 3.3 Proposal 3: Decentralise the organisation and restore the director-general's authority

Criticism of UN bureaucracy is as old as the United Nations itself. Blame and demands for greater accountability frequently emanate from major UN donors, sometimes for good reason but mostly to exempt themselves from their own responsibilities. They are also raised during evaluations and audits commissioned by Member States or the secretariat itself. In response to donor pressure, UN specialised agencies have undertaken managerial reforms since the early 2000s. Most of the reforms have introduced principles inspired by the New Public Management approach: results-based management, enhanced financial oversight, development of evaluation instruments, increased internal accountability mechanisms at the level of units and bureaus, outsourcing of activities, creation of quasi-markets and extension of PPPs, transparency policy, open data systems, and greater inclusion of civil society organisations (CSOs) and other stakeholders.

WHO is not immune to criticism. A key observation drawn from recent international health crises is how difficult it is for the director-general to exercise authority within the organisation. He or she is highly exposed to all forms of pressure and influence exerted by Member States, particularly major donors but also those whose geopolitical weight gives them influence in health diplomacy, such as China and Russia. The political pressure on international secretariats is relentless; all international organisations experience it. At WHO, however, the pressure is sharply intensified in times of crisis, when the director-general cannot afford to come into conflict with a powerful Member State. Despite IHR procedures, the COVID-19 crisis revealed the lack of autonomy of WHO senior management vis-à-vis the Chinese government, a pretext for the United States to announce its withdrawal from the organisation on 28 May 2020.

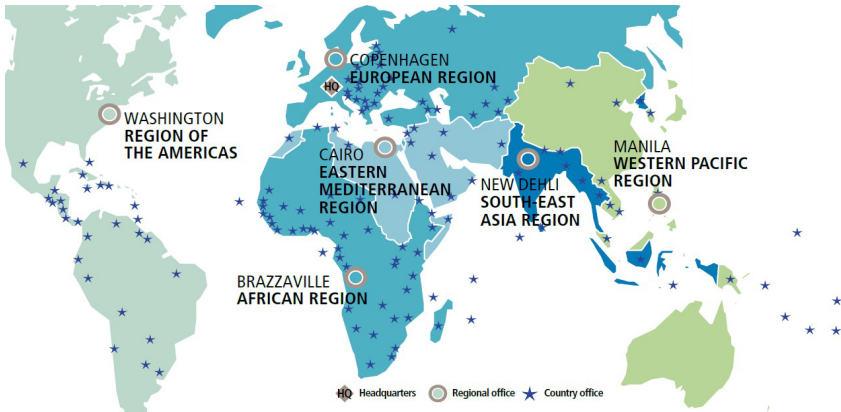
To a large extent, the contested authority of the director-general results from external factors beyond the reach of the organisation. In a global health governance framework with a mounting number of negotiation arenas and policy platforms, WHO has to contend with the rising authority of other international institutions – intergovernmental, mixed, or private – some of which have much greater financial resources. In this highly competitive and open system, only governments can decide to rebuild WHO's full legitimacy and real capacity to exercise authority under its 1948 Constitution. The issue is primarily political. It may be tackled only if the most influential members are convinced that, in the health sector, international cooperation is preferable to unilateralism. The announced withdrawal of the United States from WHO demonstrates, on this point, a clear preference for the temptation of national retrenchment.

However, beyond such external factors, there are internal organisational elements that undermine the authority of the director-general's office and affect the effectiveness of its operations. First, many recent evaluations have highlighted the work that remains to be done to increase WHO's transparency, efficiency, and accountability. They have underscored the need to improve organisational management, particularly in setting strategic objectives, measuring results at the country level, and aligning global programmes with national health strategies. WHO still faces challenges in demonstrating that funding received actually translates into public health outcomes.

Second, the voting procedure for election of the director-general could be revised towards greater transparency. A reform was undertaken in 2012–13 to ensure a more democratic process for the election of the next director-general. In May 2017, a secret ballot procedure involving all 194 WHA member States was introduced for the first time since 1948. It was used to elect the new director-general from among three finalists. The new procedure extended electoral negotiations to all WHA members. On the one hand, a more transparent election, with each country's vote made public, would allow for greater scrutiny of the future relationship between the director-general and Member States that gave him or her their vote. On the other hand, public voting would result in the identification of "opposing states", which could make their cooperation with the Director General more difficult.

Third, the organisation's regionalised structure has long been considered a major impediment to institutional effectiveness. WHO is structured into six regional offices and 147 country offices. This global infrastructure, unique in the UN system, represents a significant share of the organisation's budget. The regional offices have strong autonomy, large budgets, specific programmes, and their own legitimacy. WHO's multi-polar structure compartmentalises operations across the organisation and challenges the authority of the director-general, based in Geneva. Indeed, *The Lancet* recently referred to the existence of "seven WHO's". The Regional Office for the Americas, for example, is hosted by the powerful Pan American Health Organization, founded more than a century ago and headquartered in Washington, D.C.

### WHO's structure: unique in the UN system



Source: WHO Regional Office for Africa

WHO's multilayered organisational structure reduces its efficiency: it slows down information flow, breeds indecision, increases transaction costs, and prevents WHO from speaking with one voice. The director-general and Geneva secretariat devote much of their time to coordinating the regions in addition to activities with Member States, other multilateral entities, development banks, foundations, alliances, partnerships, NGOs, and transnational corporations.

Above all, the fragmentation and stratification increase internal rivalries. A special feature of WHO is that regional directors are elected by the governments in their region and thus derive their legitimacy from an independent nomination process. They also have their own budget, exercise full authority over their staff, and play a key role in the appointment of resident representatives (country office directors). Once elected, they thus find themselves in a situation of double allegiance. Placed under the authority of a director-general who has not selected them, the regional directors are constantly tempted to meet the expectations of the states that endorsed them by election and will decide on the renewal of their term of office. This institutional design, with regional offices politically dependent on the countries in their constituency, acts to the detriment of WHO's internal line of command. Within this framework, governments in a given region are more inclined to have direct relations with "their" WHO regional office than with the Geneva headquarters. The regional directors, on their part, are often eager for institutional emancipation from the secretariat, which can sometimes turn into competitiveness with the director-general, thus posing a risk of serious dysfunction. During the Ebola crisis, for example, the delay in WHO's response was due partly to rivalry between the Africa office and the secretariat on who would oversee the response.

To put an end to this dysfunctional organisational structure and to reaffirm full-fledged internal authority on the part of the director-general, regional directors should be chosen by the director-general rather than the health ministers in their regions. An intermediate option could be for the director-general to select regional directors on a list of several non-ranked candidates previously endorsed by the health ministers in their regions. Such a reform of electoral procedures would require broad political support as it would imply a revision of Article 52 of the WHO Constitution. A more radical measure would be to remove the regional layer and restructure the organisation so as to establish direct authority of the headquarters over the country offices. This measure would entail a complete restructuring of the organisation, including a thorough revision of the Constitution.

### **3.4 Proposal 4: Build an “IPCC for global health”**

When health crises strike the world, collection and prompt dissemination of reliable, intelligible, transparent information constitute a major challenge in organising effective responses. The same applies to engagement of research institutes and health laboratories, which are best equipped to develop testing tools, treatments, and vaccines. Beyond times of crisis, knowledge sharing is equally critical for preventing future health threats and, more importantly, achieving major public health goals in countries with limited research capacity (e.g. on maternal and reproductive health or response to chronic disease).

Stand-alone research programmes are far from being WHO's core mission. In this regard, its main activity is to collect, compile, and synthesise knowledge produced by health research organisations: national research institutes, universities, scientific foundations, public health centres, private laboratories. WHO then endeavours, using the scientific evidence, to bring about international consensus on public health priorities. It also strives to transform that consensus into policy guidelines for governments and health actors. To fulfil this mandate, the organisation recruits specialised staff with strong scientific backgrounds. Recently, it increased its research capacity with the appointment of a chief scientist – similar to the chief economists of international finance institutions – and the creation in 2019 of a Division of Data, Analytics and Delivery for Impact, headed by an assistant director-general. To build international standards, WHO operates in a variety of ways, with limited resources. Its staff are involved in collecting and aggregating health data, which they use to construct global statistics, indicators, and health goals. The organisation also relies on independent expert panels and committees that produce reports and provide key insights as a basis for WHO policy guidelines. Finally, it supports research partnerships involving scientific institutes and foundations, universities, philanthropic organisations, NGOs, and the private sector, as well as other multilateral organisations, such as the World Bank and United Nations Development Programme.

However, WHO faces increasing challenges in fulfilling its normative activity. One issue is uneven cooperation by national governments in harmonising health indicators at the global level. The COVID-19 crisis has shown how difficult it is to compare epidemic situations given the lack of a universal data collection model. WHO also operates in a highly complex international research environment where multiple private “knowledge producers” go global and play a leading role in producing and disseminating health research, data, and information. During the 2020 crisis, Johns Hopkins University (United States) became a leading institution for production of health data on the COVID-19 pandemic. Some scientific journals have also gained major influence in production of global policy knowledge. For instance, *The Lancet*’s Lancet Commissions have produced authoritative reports, following an approach similar to WHO’s expert committees. Finally, public-private platforms sponsored by governments specialise in dissemination of global data in areas of global health where WHO is expected to play a leading role; an example is the GISAID partnership for exchange of virologic data on influenza and coronaviruses.

The diversity and competitiveness of national research institutes, private organisations, and the many multi-stakeholder scientific partnerships involved in international knowledge production are essential for quality science in global health. Yet, to date, the WHO remains the only organisation with the capacity to transcribe global scientific consensus into international policy standards. Likewise, given the concentration of resources devoted to health research in favour of rich countries, WHO’s political composition and assigned missions make it a key driver of research priorities that meet the health needs of populations in low- and middle-income countries. Its scientific and policy guidance is vital for countries that have insufficient research capacity due to lack of resources and that remain dependent on international assistance for health concerns. Yet the political tensions that regularly plague WHO, including the announced US withdrawal, undermine international cooperation on health. The regular criticism to which the organisation is subject affects its credibility. Confidence in WHO dwindles with every health crisis, even though Member States’ health authorities praise its standard-setting activities in normal times.

As WHO is increasingly challenged in the field of knowledge production, it would gain from rebuilding its normative authority by forming what one might call an “IPCC for global health”. In the field of climate change, on the initiative of the G7 countries, the international community established in 1988 an innovative model of global governance giving a central voice to the scientific community: the Intergovernmental Panel on Climate Change (IPCC). In three decades, this model has not only resulted in the consolidation of international scientific cooperation on climate change, but has also been instrumental in the emergence of an epistemic community of researchers from around the world, putting governments under constant pressure from its projections and analyses. Contrary to widespread belief, the IPCC is not an independent cluster of scientists, and certainly not an inter-

national research centre. It is a hybrid intergovernmental entity. Its General Assembly comprises the 195 states represented at the United Nations, each with one vote in the panel's plenary meetings. However, the IPCC's substantive work, which consists of producing synthesis reports on the state of scientific knowledge, is carried out by independent working groups outside the bureaucratic control of a traditional international secretariat. The production of IPCC reports follows a long process of consolidation of scientific knowledge, using contradictory debate and peer review methods. It involves more than a thousand researchers from a variety of disciplines, institutions, and geographical origins.

The IPCC model has inspired governance on another global public good: biodiversity. In 2013, the Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services (IPBES) was established with a similar institutional structure, under the aegis of the United Nations. It gives a multidisciplinary expert panel responsibility for setting up working groups tasked with producing independent scientific information on biodiversity challenges.

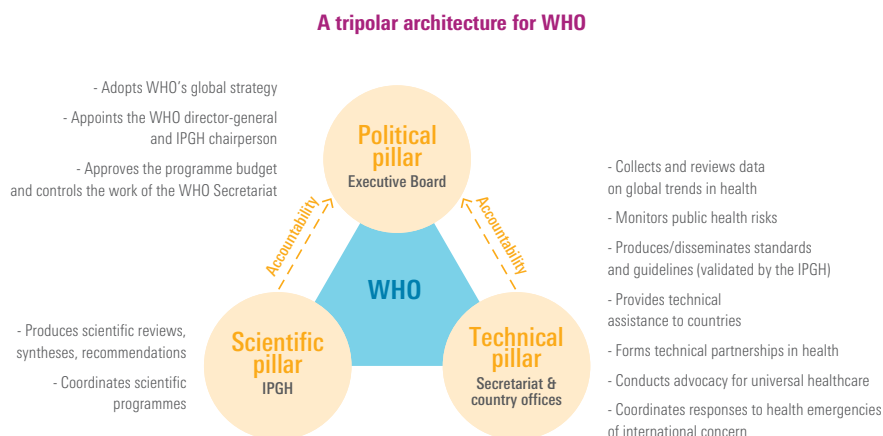
Today the IPCC and IPBES are generating a new model for integration of science and policy. Their authority stems from the establishment of internal procedures for construction of reports ensuring that the expert groups have full control over knowledge production. They operate within a scientific network that is protected from political lobbying. Admittedly, since all IPCC and IPBES assessment reports are adopted by plenary assemblies, according to procedures defined by the Member States, they sometimes end up with limited conclusions that reflect a minimum consensus balancing epistemic considerations and foreign policy priorities. Their findings are frequently criticised. Some countries (Saudi Arabia, the USA under Donald Trump, Brazil under Jair Bolsonaro) have rejected the findings of the IPCC and IPBES working groups. However, the IPCC and IPBES reports are usually unanimously approved and serve as a basis for negotiations at Conferences of the Parties on climate change and the Convention on Biological Diversity (CBD). They also inform discussions in multilateral forums on implementation of the Sustainable Development Goals (SDGs). Their findings are widely used in CSO advocacy campaigns and in protests led by transnational social movements.

Governance of health as a global public good would benefit greatly from strengthening the influence of the scientific community in multilateral health policymaking. Such an initiative could draw inspiration from the climate and biodiversity governance models. In the area of research, WHO could move towards a governance model involving the worldwide scientific community in the development of its strategic programme. In particular, at the institutional level, WHO expert panels and committees should be strengthened and incorporated into three or four main permanent, independent working groups in the branches of knowledge prevalent in global health thinking. These groups would be led by scientists, with technical support by the secretariat, on a parity basis to



ensure a balance of representation between rich countries and low- and middle-income countries within each group. A bureau elected by the WHA would supervise and coordinate the groups. The bureau would be a scientific steering body composed of the working group (co-)chairpersons and headed by an internationally renowned scientist for a fixed term. It would represent the WHO's community of independent experts. The bureau would report working group recommendations to the WHA, with no intermediation by the director-general. The working groups would not form a technostucture parallel to the Geneva secretariat but would work as a global expert network. A university or network of universities could provide their scientific secretariat, as is the case with the IPCC. The WHO Secretariat and field offices would carry out the organisation's other activities, under the director-general's leadership: international advocacy, dissemination of guidelines and standards, technical assistance to countries, and responsibility for coordinating responses to health emergencies.

The creation of an IPCC for global health, possibly called the Intergovernmental Panel on Global Health (IPGH), would result in a tripolar structure for WHO: a political pillar (WHA and executive board), a technical pillar (director-general, secretariat, and country offices), and a scientific pillar (IPGH). In this model, the voice of the global scientific community would be framed in such a way that it would appear more unified and influential on major national health strategies. As is the case with the IPCC on climate issues, one of the IPGH's virtues would be that, through a highly decentralised worldwide research network, it would be far better connected to national research institutions, CSOs, the media, cities, and local communities in addressing major global health challenges. It could foster global health awareness and education in various national contexts, adding pressure from below on the governments most reluctant to embrace universal approaches in health.



### 3.5 Proposal 5: Strengthen non-state-actor participation in WHO governance

Since the 1990s, the international health regime has undergone major structural changes. Health has become a global market generating huge profits as the private sector has massively invested in health research, production and marketing of health products and technologies, provision of health services, and assistance and consulting in healthcare policies. Over the past 20 years, international philanthropy has become a major contributor to multilateral health initiatives. The emergence of market-based mechanisms in global health governance and financing – particularly through PPPs – has led to the development of what has been called “market-based multilateralism”. At the same time, the major medical NGOs have established themselves as providers of essential healthcare services and key players in vaccination campaigns in the field – especially in remote areas and contexts of poverty, violence, and health emergencies. Moreover, since early in the HIV/AIDS period, advocacy coalitions and movements representing civil society have entered international arenas and pressured governments for increased funds and appropriate health policies.

In this environment, the multilateral system is experiencing significant institutional transformations. It has opened up to non-state actors in many ways. WHO is involved in complex and extensive policy networks involving global health actors with widely different statuses and roles. It needs to reinvent itself to retain leadership in setting health standards, promoting a global health strategy, providing expert assistance to governments, and coordinating research. Its UN intergovernmental framework, established in the mid-20th century, has become increasingly irrelevant to the reality of an international regime where power relations involve multiple actors and where the sources of influence and legitimacy have diversified.

The newest multilateral health mechanisms have integrated these developments in their internal governance by incorporating the diversity of global health actors into their executive bodies. The GAVI alliance, the RBM Partnership to End Malaria and the Global Fund to Fight AIDS, Tuberculosis and Malaria, for example, were established with governance structures that ensure board representation from NGOs, networks of the people who are the most vulnerable to or affected by given diseases, private foundations, the health industry, research institutions, and multilateral organisations. Within the UN system, UNAIDS was the first entity to establish formal CSO representation on its governing body, recognising the critical role played by community-based organisations in the fight against HIV/AIDS.

Like other UN organisations, WHO had established mechanisms for participation of non-state actors by the late 1990s. Under Gro Harlem Brundtland’s leadership, it multiplied communication

channels and partnerships with the private sector and NGOs. During Margaret Chan's term, relations with industry became more strained, resulting in a more stringent set of rules governing WHO's relations with its partners: the Framework of Engagement with Non-State Actors (FENSA), adopted in 2016. However, FENSA's rules are basically limited to improving transparency in relations between WHO and private businesses. The framework provides no mechanisms enabling non-state actors to be actively involved in WHO governance. To manage external relationships, WHO operates through a framework establishing "official relations" with more than 200 diverse organisations (foundations, specialised NGOs, advocacy groups, professional associations and federations, business-oriented private alliances, research institutions, and so on). This status allows accredited actors to make public statements at meetings of WHO governing bodies and to organise side events at the WHA. However, the rules prevent effective participation and influence of CSOs based in the Global South, most of which remaining poorly resourced and unable to maintain permanent representation in Geneva.

A substantial reform ensuring more active participation by non-state actors in WHO governance would strengthen the organisation's authority by broadening the bases of its legitimacy. It would also encourage non-state actors to re-engage with the organisation, as the past few years have shown that they can easily channel their resources towards new mechanisms that better reflect their real influence. A few years ago, it was suggested that the WHA establish a third committee to enhance non-state participation. The assembly's activities currently rely on Committee A on Technical and Health Issues and Committee B on Administrative and Financial Matters; they prepare and approve proposals that are submitted to WHA plenary sessions. The creation of a Committee C open to non-state actors would have the great advantage of providing a forum for WHO stakeholders and partners, whose interests often conflict. Such a committee would help in the quest for common solutions on health issues while limiting individual lobbying and similar practices. It would also allow more transparent and possibly deliberative expression by civil society, industry partners, and NGOs.

Inclusion of the corporate sector in governance recognises that WHO needs to work in close coordination with all actors in global health, whatever their aims and orientations. As corporations play a leading role in global health networks, they cannot be left out of the multilateral health policy agenda. Yet such recognition requires increased safeguards. WHO experts involved in setting policy guidelines and standards would need to be better shielded from lobbying by the private sector, including many actors that indirectly promote industry interests, such as interest groups, corporate alliances, professional associations, business-friendly NGOs and foundations, consulting firms, and industry-funded research bodies. WHO strengthened its regulations on conflicts of interest and undue influence of private actors, particularly in the area of nutrition policies, when it adopted

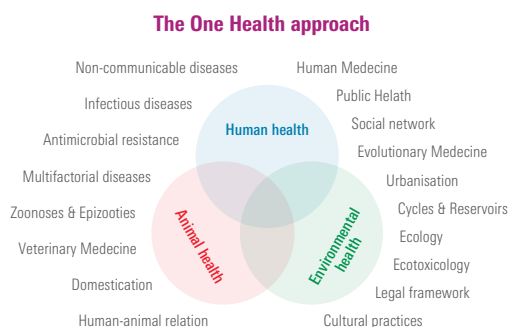
FENSA in 2016. It is also increasingly vigilant in the selection of its independent experts. But such procedures remain incomplete and lack efficiency. The FENSA's principle of "inclusiveness" has been sharply criticised by civil society organisations as posing "a new and serious threat to WHO's independence and integrity", and contradicting "the basis of all conflicts of interest policies". Reform concerning non-state actors should explore opportunities to adapt and generalise the mechanisms contained in the WHO Framework Convention on Tobacco Control for protecting health policies against commercial interests. The World Bank's safeguard policies might also provide further inspirations. A policy of transparency covering WHO's relations with the private sector would be enhanced by introducing external watchdog mechanisms based on scrutiny and surveillance, whereas current FENSA procedures only require an internal review and assessment, by a designated focal point, of WHO's engagements with non-State actors. For example, a reporting and accountability procedure involving an open-ended independent inspection panel could be triggered by any NGO that could demonstrate undue influence of commercial and profit-making interests on WHO norm-setting and policy-making processes.

### **3.6 Proposal 6: Integrate global health and environmental institutions**

Recent pandemics have spurred creation of research programmes on the ecological origins of health crises. The 2020 pandemic has catalysed global awareness of the systemic ecological fragility generated by human modes of development. It shows that the impact of human activities on the biosphere can affect human health in many ways. Expansion of agricultural land, intensive livestock farming, destruction of woodlands, trafficking and consumption of wild animals, extraction of natural resources, pollution, and the rise in the earth's temperature are causing new threats to human health.

With regard to epidemics alone, destruction of natural ecosystems significantly increases the risk of contact between humans and reservoirs of pathogens present in nature. Today, more than 60% of emerging infectious diseases are zoonoses (transmissible to humans from animals). A large majority of these (70%) originated in wildlife. In recent years, most virulent viruses have been of animal origin, including SARS, Ebola, avian influenza, Zika, and COVID-19. An expert panel convened in 2015 by *The Lancet* noted, moreover, that the effects of anthropogenic climate change could threaten the public health gains of the past 50 years; conversely, action on climate could be one of the most valuable interventions for global health in the 21st century. Overall, environmental degradation poses systemic risk to global health.

Since 2010, WHO has fostered approaches designed to integrate human health, animal health, and environmental health. It has supported the UN-led One Health approach, a joint initiative with the World Organisation for Animal Health (OIE) and the FAO, launched in 2011. The concept has gained traction in international institutions. It has led to the establishment of programmes on zoonotic diseases and antibiotic resistance. It has entered the scientific lexicon in disciplines ranging from microbiology to public health. Many health research centres recognise the value of having doctors, veterinarians, biologists, agronomists, ecologists, sociologists, anthropologists, engineers, and urban/land planners working together. Countless interconnections exist between biodiversity conservation, animal health, agricultural reforms, food safety, biological resource exploitation, economic and cultural uses of the environment, and human health. Thus transdisciplinary research should attract an increasing share of global research funding and encourage development of crosscutting operational activities at the country level.



Source: *Frontiers in Veterinary Science*, 2018

However, the One Health approach has thus far remained poorly implemented as an international policy priority. Animal health suffers from underinvestment. Multidimensional evaluation of programme performance is unsatisfactory and limited. Multiple academic, political, and economic barriers continue to hinder transdisciplinary approaches to health. Moreover, the lack of financial indicators makes it difficult to estimate the resources allocated to responses integrating human, animal, and environmental approaches. It is significant – and regrettable – that the most recent WHO and IHME reports and OECD statistics on global health expenditure make no mention of the One Health approach, nor do they propose indicators to estimate spending on multisectoral programmes. Lastly, some analysts estimate the real cost of epidemic risks for human societies to be much higher than the global expenditure to combat epidemics, most of them zoonotic diseases. Estimates of the cost to the economy range from US\$ 6.7 billion in 2009 to around US\$ 500 billion in 2018, with much higher exposure for low-income countries.

There is an urgent need for global health governance to much more effectively integrate health risk management linked not only to interactions between human societies and the biotic community (animals, plants, microorganisms, and fungal species) living in the same biotope but also to the impact of climate change on ecosystems. A multisectoral, transdisciplinary integrated approach should be fostered at every level where health and environmental policy standards are set, from the national legislative level to international regulations, including both norms set by governments through multilateral organisations and voluntary standards adopted at the initiative of market actors. To yield good results, such an approach must be inclusive at every governance level, bringing together NGOs, industry, scientific communities, health agencies, governments, and legal professions. It must also safeguard the rights of indigenous peoples and local communities.

At the international level, WHO's mandate in disease prevention and surveillance gives it a unique responsibility in efforts to mainstream international health responses with biodiversity and climate. Yet epidemic risk management includes no large-scale governance mechanism to integrate global health and biodiversity conservation. While the One Health initiative involves WHO, the OIE, and the FAO, it does not include international organisations specialised in the fight against biodiversity degradation. Neither the United Nations Environment Programme (UNEP) nor the secretariats of the CBD, the Convention on International Trade in Endangered Species of Wild Fauna and Flora (CITES), the Ramsar Convention on wetland protection or the Convention on the Conservation of Migratory Species are involved in multilateral programmes to combat zoonotic diseases. Nor does global health risk governance include international organisations involved in urban development (such as UN-Habitat), financial institutions supporting major infrastructure development (e.g. World Bank, Asian Infrastructure Investment Bank), institutions setting voluntary standards (such as the International Organization for Standardization), climate bodies (e.g. Framework Convention on Climate Change, IPCC) or environmental NGOs (such as WWF and the International Union for Conservation of Nature).

An integrated perspective inspired by the One Health approach could rally governments around global health security as a unifying concept. Global health security – the set of conditions enabling human societies to collectively prevent, detect, monitor and respond to global health risks – includes the capacity not only to respond to health emergencies (such as infectious diseases), but also to anticipate and reduce longer-term threats (such as antimicrobial resistance and the effects of pollution on human health). The institutional design for global health security governance is a challenging issue, as it would take the form of a “complex of regimes” interconnecting the fields of health, environmental protection, biodiversity, climate, agriculture and food security, trade, and habitat and urban development.

An international partnership was established in 2014: the Global Health Security Agenda (GHSa). Supported thus far by 67 countries, it seeks to address the issues of biosecurity, antimicrobial resistance, and the interface between humans, animals, and the environment. However, its structure reflects the gap still to be bridged in the global health sector: the partnership is tied to a US initiative and gives the private sector significant weight in internal governance, relegating UN specialised entities (WHO, OIE, FAO) to a subsidiary function as “permanent advisers”. Time will tell whether this initiative is likely to expand under the auspices of the US government, or whether WHO could be recognised as a lead agency in a multi-stakeholder governance mechanism whose format is yet to be specified. Although the latter scenario is unlikely as long as confidence in UN institutions remains eroded, it is useful to define conditions that would enable WHO to spearhead an integrated response to health threats.

To secure its legitimacy, such a response would need to be preceded by an evaluation and prospective study undertaken by an international high-level commission along the lines of the Brundtland Commission, which in the late 1980s promoted integration of environmental and development issues. The commission would be tasked with drawing up proposals for global health security in line with the SDGs. At the legal level, the IHR should be revised – or incorporated into a new legal instrument, which might be called the Framework Convention on Health Security – to redefine the liability regime for countries regarding infectious diseases, using an approach combining human health with animal and environmental health. With regards to research, one of the independent working groups of the proposed Intergovernmental Panel on Global Health (see proposal 4) could focus on global health security. In collaboration with the IPBES, the group could synthesise knowledge from transdisciplinary approaches to global health. At the technical level, enforcement of the framework convention would necessarily involve all UN and non-UN specialised agencies (WHO, FAO, OIE, UNEP, World Bank, CBD, and CITES, among others), with each producing technical assistance to countries in its area of expertise. To foster institutional convergence and information sharing, the multilateral community could not function without a global coordination mechanism. The United Nations often sets up inter-agency task forces, but they are merely information-sharing forums. A much more integrative solution could be inspired by steering mechanisms in the fields of humanitarian aid and the fight against HIV/AIDS.

Health is a common good of all humankind. It cannot rely only on national responses. Pathogens travel in a biosphere that knows no borders, languages, or human cultures. A return to health sovereignty would be a disaster when it comes to responding to future health crises such as COVID-19. Human health is inherently global health. It cannot be protected or promoted without effective global governance. To develop such a response, WHO must be reinvented. It must not be sidelined.



## 4 | NOTES AND REFERENCES

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marred by conflicts of interest. WHO is now complying with a reinforced transparency policy (committee members must declare their interests, and their CVs are published).

- 52 For example, WHO has been working since 2018 on a programme aimed at harmonising global health data with the Institute for Health Metrics and Evaluation, a Seattle-based academic statistical institute supported by the Gates Foundation. WHO also collaborates with private foundations such as the Council on Health Research for Development and the Global Forum for Health Research.
- 53 In the 1960s and 1970s, the Christian Medical Commission, established by the World Council of Churches, played a similar role. It helped bring international recognition to the issue of primary healthcare.
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- 60 The global healthcare market reached a value of \$8.45 billion in 2018, with a compound annual growth rate of 7.3% since 2014. It is projected to reach nearly \$11.9 trillion by 2022 (*Healthcare Global Market Opportunities and Strategies to 2022*, The Business Research Company, June 2019). In this market, pharmaceutical industries make the largest profits.
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