

## PHM Commentary on WHO Reform: Health governance: a leadership priority for WHO

The second section of [EB133/16](#), dealing with Health Governance, is a redraft of [EB132/5 Add.5](#) from Jan 2013. EB132/5 Add.5 had been very late in being made available to members of the EB in January and several members indicated they had not had time to read it properly. (See [records of sixth meeting](#) from page 77). After consideration the EB decided [Decision 132\(13\)](#) to continue its examination of this issue at EB133.

The main change between EB132/5 Add.5 and EB133/16 (the section health governance) is that health governance is now characterised as a leadership priority rather than a strategic priority.

### Summary

The paper starts with Fidler's definition "the use of formal and informal institutions, rules and processes by states, intergovernmental organizations, and non-State actors to deal with challenges to health that require cross-border collective action to address effectively".<sup>1</sup>

The paper then comments on the broadening of the 'health governance agenda' and identifies as new features: multiple voices (NGOs, donors, corporations); new actors (especially new 'development partners'); wider concerns (apparently new concerns for equity and fairness); new distinction between governance of and governance for health.

Health governance is then analysed from three angles:

- first, 'positioning and promoting health', eg advocating for UHC and health in the post-2015 development agenda; advocating for health in the Rio +20 process; engagement in development cooperation coordination; health in regional integration;
- second, engaging with the wider governance field in relation to WHO's leadership priorities such as UHC, NCDs (and SDH), IHRs, and access & innovation;
- implications for WHO reform, including increasing need for WHO's convening role, managing WHO's relations with outside stakeholders (including IGOs and NSAs) and through partnerships; improved internal coordination within WHO, improved international health capacity in MSs.

The EB is invited to note the report, its analysis and its conclusions.

### Comment

An understanding of the significance of economic globalisation in shaping health and framing global governance is essential to understand the relations between global governance and health but there is no mention of globalisation in this report.

The term 'globalisation' used in three different ways: first, as a reference to 'the global village' (the shrinking of distance with air travel and modern communications); second, as a

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1. Fidler DP, Calamaras JL. *The challenges of global health governance*. New York, Council on Foreign Relations Press, May 2010.

reference to increased economic integration globally; and third, as a reference to the increasing degree to which peoples all over the world are subject to the same political, economic and military disciplines of global governance. All of these different usages are relevant to GHG and the role of WHO.

Globalisation as ‘the global village’ is particularly relevant to the spread of communicable disease and microbial resistance. The IHRs, the development of the PIP framework and WHO’s limited attempts to address anti-microbial resistance exemplify WHO’s response to globalisation understood as the global village.

Globalisation as ‘global economic integration’ influences health in a myriad of ways, most strikingly through the instabilities and imbalances of the global economic regime and the ways these have locked the bottom billion in poverty with all the health consequences of that. The fact that some countries spend \$44 per head on health care and others spend \$7,000 per head on health care reflects the dynamics of the global economy, as it is presently regulated. The shortfalls in the MDGs reflect in large degree the imbalances of the global economy.

Globalisation, understood in relation to the political, economic and military disciplines of global governance has far reaching health impacts. This is a political regime which serves to shore up the injustices of the global economy. The failures of global governance in relation to odious debts, capital flight, tax avoidance and transfer pricing are part of the regime which locks the bottom billion in poverty. The tightening net of free trade agreements and bilateral investment agreements, which protect corporations against policy measures for health, is also part of this regime.

Throughout the WHO Reform process there has been a chorus to the effect that WHO is a normative body and should not get involved in the politics of global health. In 2006 the Assembly adopted [A59.26](#) which calls for WHO to support MSs in promoting policy coherence across trade and health. Not surprisingly none of WHO’s large donors have been willing to fund this work and the protection of health in the context of new trade agreements has been badly neglected.

The paper EB133/16 recognises as one of the challenges to WHO’s role as the global health leader, the proliferation of global health initiatives and public private partnerships over the last 15 years. These GHIs have mobilised significant funds and have greatly fragmented global health policy making as well as national health systems. The emergence of GHIs was a direct response to the challenges to the TRIPS regime as a consequence of the emergence of anti-retroviral treatments. Deliberate choices were made not to direct these new resources through WHO.

Recognising the rising significance of globalisation in the shaping of population health does not mean that WHO should seek to take over economic and political governance but the principle of ‘health in all policies’ does suggest that WHO should look towards strategies for policy coherence; should be able to prosecute the health agenda by engaging with the real structural determinants of health.

EB 133/16 speaks about WHO’s leadership priorities in relation to MDGs, non-communicable diseases, UHC, and access to medical products. However, in terms of addressing the dynamics of globalisation which frame these challenges, WHO’s performance

has been disappointing. Par.54 and 55 of the document comment that there is a “growing political interest in health” and “many of the areas, rules and regimes that have a positive impact on health are managed by different international institutions”. These other institutions include the World Bank, WTO, WIPO and a raft of trade and investment agreements. In these fora health is understood as an economic resource, if it is considered at all. It is certainly not treated as a basic human right.

WHO has very limited institutional autonomy in terms of advancing global governance for health, because the majority of its funds are provided via extra-budgetary voluntary contributions. This ensures that WHO does not do anything that runs counter to the interests its state and non-state donors.

WHO’s role in global health governance, the second part of document EB 133/16, is reported here upon request by the 132<sup>nd</sup> EB meeting. However, the EB is not requested to take action or decide on the WHO’s in Global Health Governance. Unless the EB decides on an intergovernmental process and mechanism to develop and clarify WHO’s role in global health governance, this part of the reform will fall short of its expectations, and further undermine WHO’s legitimacy as the leading authority in global health. Unfortunately, that is actually the aim that some states and non-state actors are pursuing.