

D1 | WHO REFORM: FOR WHAT PURPOSE?

In this chapter, we refer to the roots of the global health crisis in the contemporary regime of economic globalization and then argue for a theory of global (health) governance that goes beyond simply listing those international institutions that deal with health issues. An expanded theory of global governance would also recognize imperialism and big-power bullying; acknowledge the historic competition between the nation-state and the transnational corporation as the principal agent of governance; and contextualize governance within the emerging class relations between the transnational capitalist class, the diverse national middle classes and the more dispersed excluded and marginalized classes of both the periphery and the metropolis.

Understanding the global health crisis in relation to the crisis of neoliberal globalization, and locating political control within this expanded theory of governance, the chapter points towards the kinds of capabilities that WHO would need if it were to seriously pursue Health for All (HFA) in this context.

The current reform programme does not rate highly against these criteria. On the contrary, as we noted in GHWI (GHW 2005), WHO is under continuing pressure to retreat to a purely technical role and to withdraw from any effective engagement with the political and economic dynamics that characterize the global health crisis. We conclude with some notes on civil society advocacy for the WHO that we need.

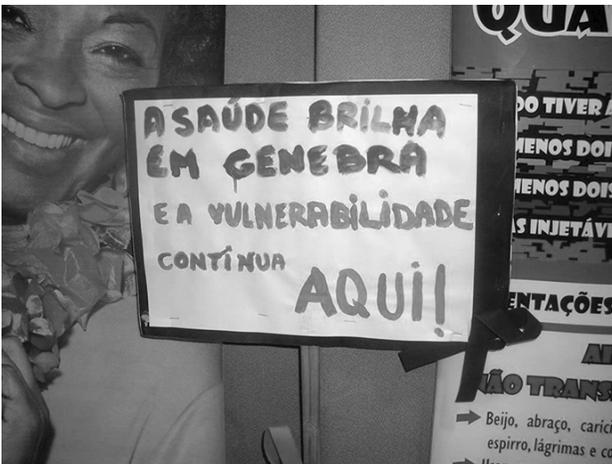


Image D1.1 Placard in Rio, Brazil – ‘Health shines in Geneva, vulnerability continues here’ (Janine Ewen)

Background to reforms in WHO

WHO has been subject to criticism (as well as appreciation) since its founding (WHO 1958; Farley 2008). In GHWI (GHW 2005) we reviewed WHO's strengths and weaknesses and explored how it might better fulfil its historic mandate as envisioned in its Constitution (International Health Conference 1946).

Our own criticisms in that chapter focused on lack of resources, poor management and lack of leadership within the Secretariat,¹ and the unequal power play between the rich countries and the low- and middle-income countries (LMICs) in the governance of WHO. We concluded with recommendations concerning: WHO's core purpose, democratization and governance, funding and programming, and leadership and management.

WHO's financial crisis came to a head in 2009 when member states were confronted with the problem of the increasing 'carry-over'; WHO was borrowing against future revenues to maintain its operations. There was self-righteous finger-wagging from many of the rich member states, whose insistence on maintaining the freeze on assessed contributions (ACs) was the fundamental cause of the crisis (see Box D1.1). The debate provided an opportunity to the rich member states to elaborate a range of criticisms of WHO management, almost to the point of suggesting that the freeze on ACs was an act of fiscal responsibility, given the many weaknesses of the organization.

As a consequence, the director general (DG) of WHO was effectively forced into adopting a major reform programme addressing a wide range of management, financing and governance issues (see Box D1.2).

Box D1.1 Member state contributions to WHO

WHO is funded through mandatory contributions from all member states, assessed on the basis of population and GDP (hence 'assessed contributions' or ACs), and voluntary contributions (VCs), most of which are earmarked for particular projects. Since the 1980s there has been a freeze on increases in ACs. Initially, it was a relative freeze in the 1980s (allowing for inflation-adjusted increases), but from 1993 onwards an absolute freeze has been imposed (at the insistence of the United States) (Lee 2009). Meanwhile, VCs have increased to a point where they account for 70 per cent of total WHO expenditure.

The prevailing discourse from those who support the freeze on ACs has been that WHO suffers from administrative inefficiencies and that a tight chokehold is necessary to discipline the organization. In fact, the inefficiencies of the organization are in large degree a consequence of the freeze; certainly, imposing the freeze is not the solution.

Assessed contributions (ACs), the spending of which is untied (i.e. not tied to a particular programme according to donor preference), totalled \$475 million in 2012. The amount paid is based on a country's population and GDP using a formula fixed in 1982.

Voluntary contributions (VCs) comprised around \$1,539 million in 2012, of which \$1,409 million was earmarked (tied) for projects chosen by the donors. Tied funding came from member states (\$564 million) and from charities, philanthropies and international financial institutions (\$748 million). The five member states making the biggest VCs in 2012 were the USA (\$208m, 100 per cent tied), the UK (\$104m, 87 per cent tied), Canada (\$71m, 100 per cent tied), Australia (\$56m, 66 per cent tied) and Norway (\$46m, 57 per cent tied).

The proportion of WHO's revenue from ACs fell from 80 per cent in 1978/79 to less than 30 per cent in 2012, owing to the combined effect of the freeze on ACs and the real increases in VCs.

In 2012, 104 member states made VCs, almost all earmarked. Eighty-five of these bilateral donors made no contribution to the core (untied) account. Among the OECD member states only five gave >50 per cent of their VCs to the core account (Greece, Belgium, Luxembourg, Denmark and Ireland). Of the 21 countries globally with GDP >\$500 billion, 19 contributed VCs; the donations were completely tied in 13 out of those 19 countries. Of the 149 countries with GDP <\$500 billion, 75 contributed VCs; the donations were completely tied in the case of 64 countries.

Among the 33 OECD countries, funds contributed to WHO (assessed/received plus voluntary), expressed as a proportion of GDP (\$ contribution per million dollars of GDP, pm GDP), vary very widely:

- 6 countries gave >\$50 pm GDP (Luxembourg, Norway, Finland, Canada, UK, Sweden);
- 15 countries gave >\$10 pm GDP but <\$50 pm GDP (Australia, Netherlands, Denmark, Belgium, Ireland, New Zealand, Switzerland, USA, Germany, Korea, France, Slovenia, Italy, Japan, Austria);
- 6 countries gave >\$5 pm GDP but <\$10 pm GDP (Mexico, Estonia, Czech Republic, Poland, Slovakia, Turkey); and
- 5 gave <\$5 pm GDP (Hungary, Chile, Greece, Spain, Portugal).

Source: WHO revenue data from A66/29, A66/29 Add.1 and A66/30. GDP data (in current US\$) taken from World Bank data

Evaluation of the reforms

Let us, first, analyse the different elements of reforms in WHO carried out since 2009. It is possible to identify some elements that are sensibly conceived, rationally framed and likely to be successful. These include:

- improved evaluation practice, building a learning culture;
- harmonization of the work of the six regional offices;
- insistence on donors paying the full overhead costs associated with their earmarked VCs;
- improved accounting; and
- ‘organization-wide resource mobilization’ (controlling the competition between clusters and regions for donor money).

On the other hand, some of the reforms are likely to have a negative effect on WHO’s role in protecting public health. These include:

- Development of new protocols to govern ‘the engagement with non-state actors’ to protect the governing bodies and the Secretariat from improper influence. The WHO has been very slow in dealing effectively with this issue (see Box D1.5 and D1.6 later).
- The new ‘financing dialogue’ is about asking the donors to fund the budget rather than WHO agreeing to do whatever the donors are interested in funding. This begs the main issue: the freeze on ACs denies WHO access to adequate, flexible funding to ensure that the work programme adopted by the member states is appropriately funded.

Addressing these weaknesses of the reform programme is important, but there are also more fundamental questions that need to be addressed. These include questions regarding the concrete shape that WHO should acquire, if it is to be effective in dealing with the contemporary global health crisis, having regard to the prevailing structures of global health governance (GHG). (See Chapter A1 of for a detailed account of contemporary neoliberal globalization and how, through different pathways, it has a profound impact on health and healthcare.) Before we envision the role that WHO should be playing and the kinds of reforms that would be needed, we take a closer look at the contemporary landscape of GHG in the context of the global health crisis.

Global health governance: a sub-domain of global economic governance

While WHO operates in the field of GHG, it is important to understand that this field is a sub-domain of the wider field of economic and political governance. In contrast, much of the discourse around WHO reform and its role in GHG tends to treat GHG as an autonomous domain of governance constituted in largely institutional terms, including: WHO, other UN intergovernmental bodies, the international financial institutions, philanthropic foundations, the myriad public–private partnerships (PPPs) involved in ‘development assistance for health (these are discussed in detail in GHW 2008), the pharmaceutical industry and other healthcare supply industries, the large bilateral donors (including in particular USAID, PEPFAR, the UK and the

Box D1.2 Key elements of WHO reform, 2009–14

Management reforms

- increased focus on outcomes in planning, management, and evaluation;
- improved evaluation practice;
- harmonization of the work of the six regional offices;
- closer alignment of the work of the different levels, from headquarters to regional office to country representative;
- improved risk management;
- improved financial controls;
- improved people management (mobility, performance management, staff development and learning, recruitment and selection).

Financing reforms

- adoption of the new ‘financing dialogue’ (asking the donors to fund the budget rather than agreeing to do whatever they choose to fund);
- insistence on donors paying the overhead costs incurred through their earmarked funding;
- improved accounting;
- improved budgeting and resource allocation;
- ‘organization-wide resource mobilization’ (controlling the competition between clusters and regions for donor money).

Governance reforms

- improved communication between the Secretariat and member states;
- a greater role for the Programme Budget and Administration Committee of the Executive Board;
- streamlined decision-making in governing bodies;
- protection of governing bodies and the Secretariat from improper influence.

EU), non-government organizations (such as Médecins Sans Frontières, Oxfam, World Vision and various specialist professional groupings) and various think tanks and academic centres.

This institutionally defined picture of the global health landscape is useful in thinking through many of WHO’s involvements, such as: food standards, vaccine development, distribution of bed nets, and the provision of advice regarding healthcare financing. However, this is a very inadequate picture when it comes to trying to make sense of (for example):

- The USA threatening India with trade sanctions under Special 301² over its (TRIPS³ compliant) patent law, in order to prevent Indians having access to cheap generics;
- the role of investor state dispute settlement in plurilateral trade agreements in preventing countries from regulating for public health;
- the geopolitics of refugee flows and the breaching of human rights standards towards asylum seekers;
- unemployment, poverty and ill-health in rural areas of developing countries in the face of dumped agricultural products;
- the race to the bottom in terms of taxation, public services, labour rights and environmental regulation associated with the auction for foreign investment to create jobs.

The purely institutional view of global health governance does not help if we are hoping to see WHO confront the global health crisis and its roots in the global economic system.

To properly specify the role that WHO should be playing in relation to the global health crisis (recognizing the degree to which that crisis is rooted in neoliberal globalization) requires that we contextualize WHO and its role in relation to the political control of the global economy, not just the institutions that have explicit functions in relation to health. In order to do so, first we need to examine the dialectics in power relations that are part of the political economy of the globe.

Firstly we need to utilize dialectical analysis, in particular locating the institutional picture sketched above in relation to the contentions and solidarities defined by:

- big powers versus small powers; rich countries versus low- and middle-income countries;
- the nation-state, as a unit of governance, versus the transnational corporation; and
- the transnational capitalist class (TCC) (Robinson 2004) versus diverse national middle classes and dispersed excluded and marginalized classes.

The WHO is clearly dominated by the big powers, particularly in their role as donors. Thus it makes limited sense to speak about undifferentiated ‘member states’ (as if all member states are equal). Big-power ‘bullying’ is evident in relation to the implementation of resolutions by WHO that the big powers do not like. Big-power threats are normally veiled and delivered behind closed doors, but in the case of WHO’s resolution WHA59.26 on ‘Trade and health’ they have been quite overt (see Box D1.3).

Another useful analytic tool for thinking about GHG is the contention between the nation-state and the transnational corporation as alternative and competing units of global governance. This underlies a central ambiguity in much

Box D1.3 Threat of funding reprisals stymies action around trade and health

The need to encourage closer policy coherence between trade agreements and public health goals was recognized in a sequence of WHA resolutions from 1996 onwards. The principle was explicitly articulated in Resolution A59.26 on ‘Trade and health’ in May 2005.

The USA was critical from the first, accusing the Secretariat of being ‘against industry, free trade, and intellectual property’ when the resolution was being considered in the EB in January 2005. Two very high-profile interventions by US diplomats during 2006 made it clear that effective action on this resolution would not be looked upon favourably (Legge 2013).

Soon after the passage of A59.26 the Secretariat indicated that it was working on a ‘tool’ to assist countries to assess trade agreements from a public health point of view (WHO n.d.). The tool has never been published although it was submitted to the Secretariat in 2009 (Hawkes et al. 2010).

The Secretariat has done very little at the global level to implement the requests of A59.26 although some regional offices have been able to make some progress under the radar. Nevertheless it is clear that the lack of donor funding and the threats of more drastic funding reprisals have contributed to WHO’s failure to effectively implement the resolution on trade and health.

of WHO’s work, including for example its relationship with the pharmaceutical or the food and beverage industries. The use of terms like ‘multi-stakeholder partnerships’ to describe WHO’s relationships with ‘big pharma’ and ‘big food’ obscures the deep conflicts of interest between the corporations and the goals of public health and bestows on the corporations a certain legitimacy to work alongside WHO and the member states who constitute it.

The tension between the nation-state and the TNC is nowhere sharper than in relation to taxation, and indeed whether TNCs should pay tax. Notoriously the prevailing global regime encourages TNCs to arrange their ownership structures and global production chains in such a way as to pay little or no tax. This is of critical importance in terms of health systems development, which is hugely constrained by the refusal of TNCs to pay tax and the pressures of ‘tax competitiveness’ (the race to the bottom in terms of levels of tax and public expenditure). The emergence of ‘investor state dispute settlement’ in plurilateral trade agreements also illustrates very clearly the pressure to whittle away the sovereign rights of the nation-state in favour of the stateless TNC.

The absence of class analysis from most (if not all) of the available commentary on GHG is also a limitation. Such an analysis, in the context of neoliberal globalization, needs to take cognizance of the ‘transnational capitalist class’ (TCC). The TCC has been described as a class group embedded in new global circuits of accumulation rather than in national circuits. The TCC draws its membership from most countries around the world, North and South, and constitutes a nascent global ruling class. The TCC differs sharply from national middle classes and various marginalized groupings in its collective self-consciousness, common assumptions and shared purposes (Robinson 2004).

One of the tools of global governance, which is very much in the hands of the TCC, is ‘the discipline of global markets’. The propensity of speculators to buy and sell currencies, commodities, shares, bonds or derivatives in response to the policy choices of sovereign governments is a powerful limitation on such choices. A government which declares that it is planning to protect domestic industry will experience capital outflows, depreciation of its currency and reduced credit ratings. While such decisions by the speculators are generally conceived solely in terms of material outcomes they express in a more pervasive way the interests of the TCC.

Class-based analysis can also provide useful new insights in relation to discussions of ‘development’ and health, as in ‘development assistance’, the Millennium Development Goals or the post-2015 ‘development agenda’. The TCC has been very effective in constructing ‘development’ as something that refers only to ‘underdeveloped’ countries (the rich capitalist countries are presumed to have achieved the pinnacle of development); in presenting ‘development’ as a process mediated by charitable giving (as in ‘development assistance’); and in conflating ‘development’ with the treatment of particular diseases (particularly diseases that jeopardize the legitimacy of the prevailing world order) (see also Chapter C1).

Framing global health governance purely in terms of a pluralism of institutions has the further effect of excluding consideration of the domain of ideas, information, knowledges and ideologies (Althusser 1971; Herman and Chomsky 1988). In the field of GHG ideological assumptions are embedded in highly technical and information-rich discourses, including those produced by some of the leading academic centres, such as Harvard University and the London School of Hygiene and Tropical Medicine or the OECD. The ideology of neoliberalism (Harvey 2005) plays a critical role in maintaining the global economy on its unstable, inequitable and unsustainable trajectory. In doing so it contributes to reproducing the global health crisis.

To construct the global health landscape solely in terms of institutions engaged in health programmes renders invisible some of the key dynamics with which WHO needs to deal. In the lead-up to the post-2015 ‘development agenda’ the WHO Secretariat has campaigned strongly around the slogan

of ‘universal health coverage’ or UHC. The Secretariat negotiated a broad alliance with the World Bank, bilateral donors and various philanthropies in the pursuit of UHC. The price that the Secretariat paid for this alliance is an acceptance of the World Bank’s preferred health system model of mixed public/private service delivery and stratified multi-payer health insurance markets with a minimal safety net for the poor. (See Chapter B1 for a more detailed discussion of the dominant model of UHC being promoted today.) The World Bank’s policy preferences reflect the power of the neoliberal world view in an institution owned and controlled by the leading capitalist powers.

These analytic frameworks, taken together, provide us with the tools to understand the political environment in which WHO functions. For example, the purchase of political influence by corporations through campaign donations in order to drive trade policy (with consequences for small farmers, manufacturing employment and public policy space) may be understood in terms of both big-power bullying, the agency of particular TNCs and the theoretical tension between the sovereignty of the nation-state and that of the TNC.

The features and capabilities of the ‘WHO we need’

We have sketched a number of different ways of understanding the global health ‘landscape’ within which WHO works. Much of WHO’s present work programme is valuable and essential. Such programmes should be supported and continued. However, in the face of the global health crisis and the prevailing landscape of global health governance, WHO needs new capabilities. We discuss in the following sections some of the most important areas where WHO needs to reorient its approach and acquire new capabilities.

Abolish dependence on donors WHO needs to be free of the yoke of the donors if it is to engage with the structures of global governance which reproduce the global health crisis. WHO’s dependence on donors (especially those who contribute ‘tied’ funds) will continue as long as the freeze on assessed contributions remains in place and the Secretariat will remain unable to progress resolutions which challenge the interests of the rich countries. The ‘funding dialogue’, initiated by the WHO to address the problem of being dependent on donors who provide ‘tied’ funding, is an expensive charade.

The freeze on ACs has been mainly driven by the USA as part of its opposition to (in sequence): the Code on the Marketing of Breast-milk Substitutes; the Essential Medicines List; the Primary Health Care model; the Framework Convention on Tobacco Control; and most recently (2006) the resolution on Trade and Health.

The prevailing discourse from those who support the freeze on AC has been that WHO suffers from administrative inefficiencies and that a tight chokehold is necessary to discipline the organization. In fact, the inefficiencies of the organization are largely a consequence of having to manage two sources of



Image D1.2 The World Health Assembly in session in Geneva (Camila Guigliani)

funds, assessed and untied versus tied voluntary contributions. The former, the smaller tranche, is available to support what the WHA commits to, through its resolutions. The latter, vastly overshadowing flexible funds, is available to support what the donors want WHO to do (and by non-funding to prevent WHO from doing what they, the donors, do not support).

The ‘financing dialogue’ (as part of the current reform programme) was conceived as a way of encouraging donors to support the WHA-adopted programme budget rather than commissioning WHO to deliver the programmes that they favour. However:

- the transaction costs associated with the financing dialogue and the mix of revenue sources are huge, in terms of senior-person time and cash expenditure on dialogue;
- the large donors (bilaterals, private philanthropies, corporations and IFIs) continue to exercise control over WHO’s programme;
- important initiatives commissioned through the WHA are being held up for want of funding support; these include: medicines regulation, trade and health, action on junk food.

The urgent needs now are to increase assessed contributions and to increase the flow of voluntary contributions to the core account: first, by increasing the proportion of voluntary contributions going to the core (untied), which is presently very low, and secondly, by increasing the level of voluntary contributions from the emerging economies (presently very low). The Stage II External Evaluator (PricewaterhouseCoopers 2013) has called upon member states to fulfil their ‘duty of care’ to the organization. This is an important and timely warning.

Box D1.4 The story of IMPACT

An item appeared on the agenda of WHA61 (May 2008) which surprised a number of member states. The item, named ‘Counterfeit medical products’, had not been mandated by any resolution of the Assembly, but had been included on the agenda at the request of the UAE and Tunisia (at the EB122 in January 2008) without substantive discussion.

The accompanying Secretariat document (A61/16) described with some pride the establishment of the International Medical Products Anti-Counterfeiting Taskforce (IMPACT) and the work which had been progressed through IMPACT since its launch in 2006. The document listed the IMPACT ‘stakeholders’, including strong representation of the research-based pharmaceutical manufacturers.

The Taskforce had been established in 2006 and was funded (nearly US\$2.6 million) by contributions through the European Commission and the governments of Australia, Germany, Italy and the Netherlands (altogether 68 per cent) and by WHO (28 per cent). It also benefited from significant in-kind support from the pharmaceutical industry.

The purpose of IMPACT from an industry point of view was to drive stronger IP protection. The strategy involved highlighting the dangers of substandard or falsified medicines while promoting policy initiatives which were directed to protecting branded pharmaceuticals from generic competition. Critical to this strategy was the ambiguous use of the term ‘counterfeit’. In the TRIPS agreement ‘counterfeit’ is defined as a trademark violation, but under pressure from the pharmaceutical industry WHO had adopted a definition which conflated IPRs and quality, safety and efficacy (QSE).

The shortfalls with respect to medicines regulation which had allowed the flow of substandard medicines was a consequence of the funding crisis of WHO and lack of donor support for comprehensive medicines regulation. However, this had led to a situation where, because falsified or adulterated drugs were circulating widely, the scare campaigns implemented by IMPACT were effective in persuading some governments to adopt higher levels of IP protection. A key element in this hoax was the conflation of IP protection with QSE standards.

For more details regarding the IMPACT saga, see GHW3 (2011). For follow-up reporting, see also WHO Watch (2013).

Preserve WHO’s status as an intergovernmental organization (IGO) WHO’s status as an IGO must be preserved; the governance of WHO should not be shared with PPPs, philanthropies, bilaterals or IFIs. TNCs are obliged to

focus on profit and shareholder value. Their purposes are not congruent with the mission of the WHO. The PPPs, philanthropies, bilaterals and IFIs are all, in various ways, accountable to different sets of TNCs and see the world in ways which privilege the interests of the TNCs.

The member states have previously rejected the Committee C proposal (which would have created a forum within the World Health Assembly in which private sector players would have an institutionalized place in the governance of WHO). Member states also rejected the proposal for a Global Health Forum which would have provided a similar entrée but outside the formalities of the WHA. Nevertheless calls for the governance structures to be opened to the donor institutions continue to surface, most recently in a report prepared by PricewaterhouseCoopers (ibid.) evaluating the progress of the reforms.

The principles of democracy are poorly realized in the modern nation-state but at least there is a rhetorical commitment to popular sovereignty. As the TNC displaces the nation-state as the principal agent of governance, so the role of citizen is reduced to that of consumer. In the neoliberal view market forces have the magical capacity to translate the aspirations of the erstwhile citizen into reality more effectively and more efficiently than the forum and the ballot box. This is a dangerous idea; it would be hard to reverse.

WHO's engagement with non-state actors One of the most controversial items on the WHO reform agenda has been 'engagement with non-state actors'. This reflects the continuing advocacy of NGOs such as IBFAN and the watchfulness of a small number of LMIC delegations in the governing bodies. The Secretariat has shown itself to be susceptible to the benevolence of the pharmaceutical industry (most notably in the IMPACT saga – see Box D1.4).

To maintain its integrity and preserve its reputation WHO needs robust risk management protocols to identify and manage the risk of improper influence, whether that influence be mediated by corporations, philanthropists, PPPs or bilateral donors. The fact that such protocols are not yet in place is reflected in the story of World Psoriasis Day (Box D1.5).

Box D1.5 World Psoriasis Day (WHO Watch 2014)

Psoriasis appeared on the agenda for the 133rd meeting of the Executive Board of the WHO (EB 133, May 2013) without any note as to how it got there. The Secretariat report (B133_5-en.pdf) provided an overview of psoriasis, still with no account of how it came to be on the agenda. In the course of EB133, a draft resolution, entitled 'World Psoriasis Day', appeared and was discussed under this item. This draft resolution, which had not been posted in the papers for the EB, Resolution (EB133.R2), was adopted after some discussion.

World Psoriasis Day is sponsored by the International Federation of Psoriasis Associations, which is supported by, among others, Pfizer, Novartis, Lilly, Leo, Celgene and Abbvie. Furthermore, twenty-two of the forty-two member associations with active websites (13 June 2013) acknowledge drug company support on their websites (including AbbVie, Leo, Janssen, Pfizer, Abbott, Ducray, La Roche-Posay, Pierre Fabrie Dermatologie, Janssen-Cilag). At least one national association receives drug company support of several million US dollars per year.

The Psoriasis Association (UK) (whose representative spoke under the banner of the International Association of Patients Organisations, IAPO) is supported by grants from AbbVie, Dermal Laboratories Ltd, Forest Laboratories Ltd, Galderma (UK) Ltd, LEO Pharma, MSD and T&R Derma. IAPO also receives extensive support from pharmaceutical companies, individually and through the IFPMA.

Drugs for treating psoriasis are among the top revenue-earning drugs in the world. Three of these – adalimumab (marketed by AbbVie as Humira), etanercept (marketed by Pfizer as Enbrel) and infliximab (marketed by Janssen as Remicade) – have been identified by Forbes in 2012 as being among the top ten revenue-earning drugs ever. The combined sales of just these three products were US\$25 billion. These high revenues have, in large measure, been sustained by IP protection and monopoly pricing. All these drugs are extremely expensive and are therefore inaccessible in LMICs; on average, a year's treatment with any of these drugs cost about \$20,000. They are also key to the healthy profit margins of the companies involved; Humira sales accounted for 51.7 per cent of the revenues of AbbVie in the first quarter of 2013.

It appears probable that the involvement of drug companies in supporting the IFPA (and its member associations), and their support for World Psoriasis Day, is part of a marketing strategy directed at expanding the global market for their products.

WHO's de facto endorsement of an event planned and organized by an organization such as the IFPA, which is funded and promoted by the pharmaceutical industry, contravenes WHO's stated position regarding engagement with non-state actors. At the very least the Executive Board should have been advised of these relationships, but they were not.

The WHO has a legitimate role in raising awareness regarding psoriasis, in promoting access to treatment and in harnessing research capacity towards finding better remedies. However, WHO's endorsement of World Psoriasis Day cannot be seen as an appropriate way to pursue these objectives.

Box D1.6 Regulation of transnational corporations

There is a powerful public health case for regulation of the TNCs (including those involved in tobacco, junk food, alcohol and medicines). There is also powerful opposition to any regulation of TNCs, including through the increasing prevalence of investor protection provisions in plurilateral trade agreements. This contradiction illustrates starkly the tension between the nation-state and the TNC as the dominating units of global governance.

The rich countries, the USA in particular, have repeatedly opposed the regulation of TNCs for public health objectives, preferring to speak in terms of ‘multi-stakeholder collaboration’, and obscuring the conflicts of interest between the corporations and public health.

The classic case is the Code on the Marketing of Breast-milk Substitutes, which started life as a proposal for a binding treaty but emerged in the form of a voluntary code because of a promise that the USA would not vote against it (which in the end they did; see Richter 2002). However, while the Code has had a positive influence, its voluntary status is a clear limitation. Recent data (WHO 2014) indicate that just over half of 199 member states reporting had implemented any principles from the Code through national legislation and just thirty-seven member states (22 per cent) had fully implemented the Code.

In contrast the Framework Convention on Tobacco Control (FCTC) is a binding treaty and requires states parties to implement the basic set of regulatory measures. The struggle to conclude the FCTC was fiercely contested by big tobacco and their allies (Roemer et al. 2005) and the struggle to control tobacco continues. The attempt by Australia to implement plain packaging (in accordance with the FCTC) has been challenged in the WTO (by Ukraine, Honduras, the Dominican Republic, Cuba and Indonesia, all of whom as member states of WHO are bound by the FCTC) and under investor state dispute settlement provisions of the Hong Kong Australia Investment Treaty by Phillip Morris Asia.

The alcohol and food and beverages industries, and their nation-state sponsors, have learned much from the fights over tobacco control and are determined to prevent the international regulation of the marketing of alcohol and junk foods.

The attempts by the Pacific Island countries to regulate the importation of fatty meats and the marketing of unhealthy lifestyles are revealing (see Chapter C3). The Pacific Island countries have high rates of obesity, diabetes and other non-communicable diseases and have explored a range of strategies to ‘make healthy choices easier choices’. However, they have

faced powerful opposition, particularly from the USA, in this project. In 2008, the US delegate to the Western Pacific Regional Committee of WHO, in opposing WHO engagement with issues of trade, stated that, ‘Diet, physical activity and health behaviour involve complex personal choices and individual priorities. The Regional Action Plan should address those complexities and the responsibility of individuals in changing their behaviour’ (Legge 2013).

Collaboration with other UN agencies Inter-sectoral collaboration has been part of public health rhetoric since Alma-Ata in 1978, but WHO’s collaboration with other intergovernmental organizations (IGOs) within the UN system has been weak. In contrast WHO works closely with the World Bank on health systems and with WTO on trade issues. The World Bank is structured to represent the interests and perspectives of the rich world, notwithstanding its rhetoric about poverty alleviation. The WTO is structurally committed to the neoliberal faith in globalized free trade. WHO should treat Bretton Woods institutions with caution. Their accountabilities, and therefore their world views and their policies, are all shaped by the interests and perspectives of the rich world.

On the other hand UNDP and the UNHRC have valuable expertise in relation to health systems and UNCTAD and the UN Department of Economic and Social Affairs (UN DESA) have high levels of expertise in trade and global economics. The UN system retains a one country, one vote constituency and in this degree remains committed to a pre-eminent role for the nation-state. In view of the ascendant role of the TNC this is an important advantage over the Bretton Woods organizations, which have no such commitment.

WHO’s collaborations with UNDP, UNCTAD, UN DESA, UNEP, UNHRC and other IGOs of the UN system need to be strengthened if it is to take effective action on the right to healthcare, trade and investment, the availability and quality of work, the regulation of TNCs (see Box D1.6), the environment, taxation (tax avoidance and tax ‘competitiveness’) and technology transfer (focusing on ‘technologies which are critical for health’), refugees, war and climate change. This is not to suggest that WHO should seek to exercise pre-eminent authority in these matters but to ensure that the decisions and programmes developed in these different UN-system IGOs reflect an understanding of the health dimensions.

Engagement in monitoring, coordinating and accountability of development assistance While WHO’s country representatives (WRs) are frequently involved in assisting countries to access ‘development assistance for health’, WHO’s lack of involvement at the global level is striking. In the current debates about ‘health in the post-2015 development agenda’ WHO has been preoccupied



Image D1.3 ‘Watchers’ at the World Health Assembly (John Mahama)

with the funding of its own programmes, in particular ‘universal health coverage’, and has failed to exercise effective leadership in relation to the flow of funds under the broad rubric of ‘development assistance for health’. Two recent initiatives in this area were the ‘Maximising positive synergies’ project (MPS) and the International Health Partnership + (IHP+). In both cases an extremely diplomatic approach was taken so as not to cause offence, but the consequence was not to cause change either.

The ‘developing countries’ necessarily approach the idea of ‘development’ very differently from the donors whose ‘development assistance’ is directed at demonstrating their concern for the poor while doing nothing about tax evasion and capital flight and continuing to drive free trade and economic integration policies which are very problematic for any meaningful programme of development. It is in the interests of the LMICs to authorize the WHO to play a more active role in relation to ‘development assistance for health’.

Support engagement of LMICs in WHO’s decision-making bodies There is an urgent need for increased support for the LMICs to play a more active role in the governing-body discussions, including capacity-building and more strategic caucusing. The rich countries come to the GB meetings having carefully researched the issues at stake and evaluated possible policy strategies. The European Union countries come to the GB meetings with a single policy position reflecting careful consideration of issues and options.

Certainly the regional committees provide an opportunity for some prepara-

tion by LMICs, especially in relatively homogeneous regions such as Africa and South-East Asia. However, caucusing in regional committees is constrained in various ways by the presence of regional directors and Secretariat staff. While Secretariat staff can contribute in providing background and options in relation to particular items they have their own interests and accountabilities. UNASUR and the South Centre and other regional coordination bodies do provide space for this kind of caucusing but there is considerable scope for strengthening this kind of support.

Stronger accountability at all levels There is a need for stronger accountability on the part of the member states for their involvement in WHO at all levels. Governments and their delegations need to be more accountable for their preparation for governing-body debates, for the policy positions they adopt and in some cases for their implementation of WHO resolutions. In particular they need to be accountable to the people who have most to gain from a more equitable and more sustainable global regime. Civil society organizations have an important part to play in holding both the member states and the Secretariat to account.

Scorecard for the current reform programme

The current reform programme does not address the real requirements as regards changes in WHO's capabilities and approach. It is not based on any coherent conception of WHO's role in confronting the global health crisis, nor a realistic account of the structures and dynamics of global (health) governance. Rather the reform identifies and seeks to address specific management weaknesses, many of which can be traced in part to the policy of zero nominal growth and the absurd funding situation WHO is in.

The proposals for a focus on harmonization (across the regions), alignment (across the levels) and 'organization-wide resource mobilization' all arise from an earlier approach to the funding crisis in which clusters and regions were encouraged to be more entrepreneurial and seek donor funding directly. The consequence of that strategy was to vastly increase tied voluntary donations, which in many cases did not cover organizational overheads (which therefore increased the drain on ACs) and which contributed to a dispersal of focus and functional incoherence at the organization-wide level.

There have been references to WHO's role in GHG in the discourse around the current reform programme but only in very general and rhetorical terms. Certainly there is nothing in the current reform programme which might strengthen WHO's ability to address the roots of the global health crisis in the instabilities, imbalances and inequities of the global economy.

The tensions among the member states and within the Secretariat over improper corporate influence and the necessary risk management protocols do not seem likely to be resolved soon. The USA, the EU and Japan see

Box D1.7 WHO Watch: democratizing global health governance

WHO Watch is a programme of engagement with the World Health Organization and global health governance (GHG) more generally, undertaken by the People's Health Movement (PHM) in association with a number of CSO partners. The broad goal of the initiative is to improve the global environment for health development by changing the information flows, power relations and alliances which frame global health decision-making and implementation. This will require developing countries finding a stronger voice in global decision-making, supported by a broadly based popular mobilization which rejects the prevailing neoliberal paradigm.

WHO is a central agent in global health governance and worth engaging with for this reason alone, but building a 'watching' capacity in relation to WHO will provide a firm basis for extending the project to the wider field of GHG. The main activities which comprise WHO Watch include:

- recruiting and training 'watchers';
- maintaining a high-quality website (www.ghwatch.org/who-watch) dealing in an integrated way with WHO governing-body meetings, agenda items and policy issues and providing a portal to other resources;
- monitoring, participating in and lobbying around meetings of WHO's governing bodies (World Health Assembly, Executive Board, regional committees);
- collaborating with developing-country governments and delegations in policy analysis around global health issues under consideration by WHO;
- strengthening the links between the local and thematic campaigns being undertaken by PHM country circles and PHM thematic networks and activism around the structures and dynamics of global health governance;
- engaging in national-level consultation with government officials regarding global health issues through delegations, deputations, national workshops and stoking a national policy dialogue around GHG issues.

the health of their TNCs as more important than the health of the global South and see a strong corporate influence on WHO's work as desirable and appropriate. The pressure to expand and formalize the input of the PPPs, philanthropies and IFIs into WHO decision-making is likewise set to continue.

An advocacy programme for civil society: 'Save WHO!'

'The WHO we need' will not emerge from the current reform programme. However, the capabilities described earlier provide the basis for a realistic

alternative reform programme for which civil society organizations and LMICs should be arguing. Box D1.7 describes ‘WHO Watch’, which is a project of the People’s Health Movement (PHM) and partner organizations seeking to strengthen the accountability of WHO at all levels.

It would be a serious mistake to write off WHO as an institutional failure. It has played a key role in global health and has the potential to continue to play a powerful and positive role. It is vital for civil society to engage with WHO (at all levels); as an arena of struggle, as an agent of change and as an authoritative voice.

Notes

1 WHO comprises ‘the Secretariat’, which includes the staff of the organization in Geneva and in regional and country offices, and the ‘governing bodies’, the World Health Assembly, the Executive Board and the regional committees.

2 Section 301 of the US Trade Act authorizes the listing of countries which do not provide ‘adequate and effective’ protection of intellectual property rights or ‘fair and equitable market access to United States persons that rely upon intellectual property rights’.

3 Trade Related Intellectual Property Rights Agreement.

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