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Viewpoint

Reforming the World Health Organization: Agreement on Need but Not on Principles and Priorities

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The need for reform of the World Health Organization (WHO) is widely accepted. WHO has a financial crisis, with a budget gap this biennium of around 22%,[1] currently being dealt with by a 25% cut in its headquarter budget and 14% cut for its six Regions. There is also a "crisis of trust," and a wide perception of mission-creep with WHO's area of interest becoming too broad.[2]

However, agreement on a "crisis" is where consensus ends. Dealing with WHO's crisis depends on differing perspectives regarding WHO's role in global health, whether loss of trust is justified, and indeed the trajectory of human health and well-being WHO is mandated to address. Any approach to these will differ depending on whether one is a beneficiary of the growing industry of global health and particularly the health security or pandemic agenda, or on the losing side of growing inequities[3] in global healthcare and wealth distribution.[4]

Two recent reports have provided almost completely opposed recommendations on fixing WHO. One, from the Center for Global Development (CGD)[5] recommends centralizing WHO functions more in Geneva, Switzerland, its headquarters, and drastically reducing resources and staff in WHO's six Regional and 150 or so country offices. It suggests WHO should concentrate more on intermittent threats such as pandemics, and less on supporting and building country-level health systems.

The second report, from the panel of the International Health Reform Project (IHRP)[6] which, of note, all three of this articles' authors are members, recommends an emphasis on subsidiarity, downsizing its headquarters and emphasizing regional and country level policy development and capacity building.

While both recognize a need for downsizing WHO overall, whilst retaining some central normative functions, CGD wants to build a more centralized WHO focused on crisis mitigation and management through vertical programs. IHRP proposes subsidiarity, decentralizing WHO concentrated on horizontal approaches to build individual and health system resilience, with an emphasis on regional and local decision-making.

To understand the root of these divergent approaches, it is necessary to acknowledge two fundamentally different understandings of the health risks that human populations face. CGD published a report in 2023,[7] subsequently quoted by a Lancet commission[8] and elsewhere, that estimated that respiratory virus pandemics kill, on average when adjusted to current population size, 2.5 million people per year, every year. This mortality rate has not been present in the past century within a pandemic, except perhaps for the 1957-1958 and 1968-1969 influenza pandemics.[9] Deaths from COVID-19 over 2020 to 2024 as recorded by WHO were lower than this estimated average per year for respiratory virus pandemics,[10] despite being the highest actually recorded in a century. CGD's estimates are based on deaths from historic epidemics, such as the medieval Black Death, which are then adjusted to today's population without adjusting for intervening changes in human nutrition, sanitation, living conditions, technology or medicine, and so overlooking major drivers of reduced overall infectious disease mortality.[11] The REPPARE (REevaluating the Pandemic Preparedness And REsponse agenda) project of the University of Leeds discussed the implications of this, suggesting that this potentially overstates naturally-derived pandemic risk based on the last several decades by orders of magnitude.[12]

For risk assessment, IHRP relied significantly on other reports of REPPARE, which examined reports from WHO, the World Bank and Group of Twenty secretariat, their citations and sources. REPPARE's published findings demonstrate a very large gap between the reports of these agencies and the agencies' own data and citations on which they rely.[13] In other words, several of the reports from these agencies published estimates which were not supported by the sources they cited. They also overlook the impact of human progress on improving health and medicine and particularly that of diagnostic technologies to detect and distinguish pathogens, interpreting an increase in ability to detect small outbreaks as purely an increase in outbreak frequency.

Aside from concerns regarding magnitude of risk,

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return on investment claims of WHO and the World Bank underpinning the pandemic investment case are based on opaque methodology, contain methodological flaws in comparative analysis against major endemic infectious diseases, and rely on assumptions that have not previously been achieved in practice such as rapid development of fully transmission-blocking vaccines.[14] It is also therefore unclear that such investment could significantly change the trajectory of an outbreak and so justify investment, should another COVID-19–like event, of the size envisioned by CGD, occurs.

The apparent discounting of prior understandings of the reasons for improvements in human health, and steady reduction in infectious disease burden, are of particular concern. It was previously well accepted in public health that improved nutrition, sanitation, education, and living conditions were the main drivers of improved life expectancy in higher-income countries. Antibiotics played an important role in the first half of the 20th century, whilst mass vaccination played an important role in specific diseases. However, the bulk of mortality reduction preceded the introduction of most vaccines.[11]

Replicating these gains in low- and middle-income countries (LMICs) has been one of WHO's major focuses, at least up to two decades ago. However, a growing health security agenda now promotes vertical programs coordinated centrally, in which specific fixes are developed for emerging threats to health, and rolled out en-masse. Rather than building country capacity and resilience, the CGD sees WHO's future as concentrated on a centralized approach of emergency response.

Similar emergency response approaches have been advocated by the Gates Foundation,[15] a significant funder of WHO and commodity-based public private partnerships of Gavi and the Coalition for Epidemic Preparedness Innovations. While pandemic preparedness is commonsense, the lack of similar large funding streams and public-private partnerships prioritizing underlying determinants of health and non-communicable diseases (NCDs) is likely to skew the global health conversation further. As an alternate approach, we argue to concentrate on building health system resilience and addressing socio-economic determinants of people's health, reducing overall vulnerability to infectious disease.[16] While the approaches are complementary, the current emphasis on centralized and commodity-heavy approaches risks concentrating resources and thus advancing a potentially less productive policy pathway.

There are also political drivers towards centralized health security over population resilience. For many donor countries, this divide is between the potential for enhancing an important manufacturing sector, versus the interests of LMICs in building local capacity and reducing persistent, economically debilitating disease burdens (malaria, tuberculosis, HIV, and childhood mortality).

Areas of Convergence

Improving national capacity and the underlying determinants of health requires economic growth, reduction in social inequalities, and understanding and involvement of local communities. It is a poor fit for investors, donors or centralized agencies. There are strong incentives for investors and donors to emphasize modeling results that promote vaccine-based solutions to outbreaks rather than reducing health burdens that require diffuse capacity development. Commodities can be counted, adjusted to a metric on deaths avoided, while no good cost-effectiveness tools exist for improved access to basic care and nutrition.[16]

For WHO itself, an attraction is a coordinating role that never diminishes as outbreaks will always occur. In contrast, successful capacity building would by definition lead to institutional downsizing. WHO is also, for 75% of its funding, bound to the specifications of its voluntary public and private sector funders with strong pharmaceutical industry ties.[17] Industry requirements for distribution and profit, make WHO important for promoting markets (the recent America-First strategy of the United States includes similar aims). Quite understandably, these donors will specify use of funds accordingly. Both IHRP and CGD note this as a problem, emphasizing greater reliance on flexible (non-specified) funding.

Two Very Different WHO Structures

The understandings of CGD and IHRP of the current status of health and risk allow some agreement on aims, but very different conclusions regarding proposals for a future structure of WHO.

Both reports are in agreement on the need, as CGD summarizes, to "*Articulate a clear vision for a lean WHO for the global good, with a laser-focus on its global comparative advantage*," and in its convening role.[7]

And in global public goods such as "*establishing international norms and standards … producing centralised resources such as data and reports that all countries can draw upon.*"[7] Guidance to countries on common health issues, and prequalification of health commodities are further areas of agreement.

However, while regional issues such as African Trypanosomiasis are mentioned, CGD sees public goods as nearly all global and best coordinated from that level, emphasizing "health security" in this context. WHO becomes an organization determining policy all countries will follow, rather than an advisory body whose global recommendations will be reviewed by countries, with WHO support, within their own context.

This leads CGD to recommend: "*stripping the WHO of almost all technical assistance and country delivery functions, with modest exceptions for outbreak and pandemic response*,"[7] leaving these activities to "*NGO, universities and consultants*,"[7] which is certainly attractive to the wider global health consulting industry.

To achieve this, CGD says WHO country offices would "*scale down dramatically*," with staff concentrated more within its headquaters in Geneva. Regional offices would cease much of their function, with country offices reporting directly to Geneva.

In contrast, the IHRP report recommends an emphasis on

subsidiarity, with a strengthening of regional and sub-regional roles and an emphasis on building resilience (health system and human) rather than centralized "security" measures. Rather than reducing regional roles, multicounty hubs would be the focus of interpreting global recommendations based on local context and priorities (seeking to optimize the "sweet spot" between economies of scale and immediate contextual relevance).

It seems clear that some WHO functions would best remain centralized, such as fostering global policy dialogue, knowledge and data sharing, and, to some extent, normative guidance, recommendations and quality-assurance for globally-relevant health issues and commodities.[6] However, extension of this into advocacy and coordination of homogenous global responses, such as those promoted during the COVID-19 pandemic, would ignore contextual differences necessary to maximize overall regional and country health outcomes. Malaria and tuberculosis continued to remove more life years in young LMIC populations while COVID-19 affected elderly Western care-home residents. Moreover, work-from-home lockdown responses clearly affected low-income day laborers differently to salaried office workers in states with strong social safety nets. Lastly, assuming the estimate of 2.5 million is correct, the claim that pandemics should be a priority for the WHO and global health ignores larger burdens associated with NCDs and their growing impact on global health. Not only are NCDs potentially a more significant priority, but also have relevance for pandemic resilience, since COVID-19 clearly demonstrated a relationship between mortality and NCD based co-morbidities.[18]

Centering decision-making at a country and regional level, driven by member states themselves, would strengthen the ability to prioritize overall health outcomes over single disease metrics while reinforcing the accountability of experts to the governments they are meant to advise.[19] This would, however, require sufficient coordination to minimize the actions of one state harming another and ensure that relevant expertise is accessed.

Ethics and Evidence

Covered at length in the IHRP reports, but not addressed by CGD, is the human rights and evidence base within which a multilateral agency must work. It may be that CGD, like IHRP, do not consider a role for WHO in dictating or mandating policy, in which case issues of bodily autonomy or individual sovereignty are less pressing. IHRP emphasizes that WHO can legitimately only be an advisory agency, if fundamental public health ethics and the concept of national ownership/sovereignty are to be adhered to.[6]

Concerns regarding the evidence base on which CGD, and WHO's pandemic approach, rely,[13,14,20] are critical as a lack of strong evidence of an expanding threat of pandemics or health emergencies relative to endemic or non-communicable diseases, and lack of clarity regarding return on investment through vertical programs, would damage the legitimacy of the directions CGD proposes for WHO. At a minimum, in choosing a course of centralization and emphasis on health security over decentralization and an emphasis on building health resilience, resolving these critical questions is essential. The REPPARE reports on risk[20] and return on investment[14] strongly suggest that this has not yet been achieved.

WHO was set up after World War II with goals of reducing health inequalities and promoting mutual support in a time of decolonization and assertion of national sovereignty. Health is defined in its constitution as physical, mental and social well-being, a vision far beyond fighting sudden outbreaks of pathogens, whatever risk one believes they represent. CGD note that LMICs that are beneficiaries of much of WHO's more traditional capacity building and technical support may dislike a path that reduces roles for regional and country input. Perhaps the question, then, should be who WHO is intended to serve.

Outbreaks can be addressed, one at a time, by centrally directed responses involving restrictions on populations and mass vaccination, with costly intensive surveillance in the hope of averting them early on. They can also be addressed by improving both health system and individual resilience. The latter, requiring local direction, also benefits other disease states, economies, and so has a potential path to self-sufficiency and true independence. A centralized response promises no such off-ramp.

If WHO is to remain relevant in an increasingly multi-polar world, expanding its presence in one of the most expensive and healthy cities on earth seems an intrinsically poor model. In choosing alternate paths for the future of multilateral cooperation, we may first need to return to basics and decide on the role of the intended main beneficiaries in determining their own health outcomes. A global health agency can be a decolonizing force, or a force to re-centralize and corral populations into the demands of vertically designed programs. It cannot be both.

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Not applicable.

Ethical issues

Not applicable.

Conflicts of interest

David Bell, Garrett Wallace Brown, and Elisabeth Paul were members of the IHRP, now "International Health Reform Panel."

Authors' contributions

Conceptualization: David Bell, Elisabeth Paul, and Garrett Wallace Brown.
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Validation: David Bell, Elisabeth Paul, and Garrett Wallace Brown.
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Disclaimer

The authors are members of the IHRP panel, which comprises 11 members originating from five continents with multiple backgrounds (medicine, public health, diplomacy and internal affairs, law, philosophy). The panel issued a technical report based on the identification of key ethical principles of global

health and a systematic analysis of the functioning of WHO along an analytical framework, compared to an ideal international health organization; and a policy report, which offers reflections on WHO reform for policy-makers. David Bell was one of the panel co-chairs, Garrett Wallace Brown was lead-editor of the IHRP technical report and a lead writer, Elisabeth Paul a lead writer of the technical report, and both were co-writers of the policy report.

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