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HOW TO SET PRIORITIES FOR THE WORLD HEALTH ORGANIZATION

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Abstract

Highlighting the unique legitimacy of the World Health Organization (WHO), this working paper explores how priority-setting for WHO can be part of efforts to make it fit for the increasingly complex challenges of the 21st century. A contextual review introduces some of the key issues in the reform debate and illustrates them with relevant examples.

The distinction between the priority global health topics to be addressed by WHO and WHO's priority roles and functions provides the basis for an analytical matrix. This matrix prompts people to reflect on how to build consensus on what the organisation is uniquely or best positioned to achieve. Recently debated reform proposals for the short, medium and long term are then structured into four categories in order to highlight important issues around priority-setting, stakeholder involvement, future financing and organisational/structural measures.

The conclusion highlights the window of opportunity that now exists for a meaningful reform of WHO. It states that priority-setting is part of the solution of a more comprehensive approach to raising standards and improving accountability.

Key Words

Future financing, global health governance, priority-setting, stakeholder involvement, World Health Organization, WHO functions, WHO reform.

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HOW TO SET PRIORITIES FOR THE WORLD HEALTH ORGANIZATION

Challenges of global health governance are moving to the forefront of the international debate. There seems to be a growing recognition of the complexity of the global health architecture and an emerging consensus about the need to strengthen the World Health Organization (WHO). This consensus was also apparent during the debates of the 128th session of the WHO Executive Board in January 2011 on the future of financing for WHO, which clearly mandated WHO Director-General Dr Margaret Chan to propose a broad reform agenda to the forthcoming 64th session of the World Health Assembly in May 2011 (*The future of financing for WHO*, 2011). This reform agenda will have to include four key areas: internal managerial reforms of WHO, changes in the way that WHO is financed, changes in the way WHO interacts with other major global health stakeholders and changes in the way WHO sets priorities. It should be relatively easy to find a consensus that WHO should be better at setting priorities and that a reform process cannot address all the proposed reforms – and possibly even all the necessary reforms – simultaneously. The greater challenge will be the question of *how* priorities should actually be set for WHO's work and which reform steps should come first. This article offers a personal view on how priority-setting could be addressed by WHO, based on experience as one of Switzerland's delegates to WHO's governing

1 The author of this working paper is the Vice-Director of the Swiss Federal Office of Public Health and Head of the International Affairs Department. He is also Chairperson of the Advisory Board of the Global Health Programme at the Graduate Institute, Geneva. This article reflects the personal view of the author and not necessarily those of the Federal Office of Public Health. The author would like to thank several colleagues for providing valuable comments on an earlier draft of this article and Margarita Ivanova for the background research.

bodies. The priority functions that WHO should fulfil must be defined in relation to key global health topics.

The need for a strong WHO has become more evident in the last decade, but WHO is currently not fully fit to fulfil its task. In addition, WHO is in a serious financial crisis, which has been clearly described by Richard Horton (Horton, 2011). This crisis should be seen as an opportunity to reform WHO based on a clear vision of its priorities. In an interdependent globalised world, the global normative health organisation, WHO, is needed more than ever; there is no alternative to a stronger but more focused WHO (Chow, 2010). The unique global legitimacy of "the WHO ensues from the fact that it is an organisation of all the world's nation-states" (Kickbusch, 2009).

The World Health Organization was set up in the aftermath of the Second World War with a Constitution which, even from today's perspective, is surprisingly modern and inspiring. This allows reforms of WHO without the need to change the Constitution. Changing the Constitution would be a very cumbersome and time-consuming process; proposed changes to the Constitution must be accepted by a two-thirds majority at the World Health Assembly and can only enter into force after being ratified by two-thirds of all 193 member states. The last minor change – increasing the number of members of the Executive Board from 32 to 34 – was adopted in 1998 and entered into force in 2005. Nevertheless, we should be careful to take note of the Constitution when defining WHO's future direction.

WHO has to learn, once again, to live up to its visionary Constitution in order to play the central role in global health that the organisation and the world expect and deserve. Article 9 of the WHO Constitution lists WHO's three organs: the World Health Assembly (WHA), the Executive Board (EB) and the Secretariat. Debates on WHO reform and priority-setting should clearly acknowledge that WHO refers not just to the Secretariat, with its more than 8,000 staff (*WHO – its people and offices*, 2011), led by a director-general, but also to the 193 member states represented in the WHA and the EB.

The current reform efforts of WHO were initially motivated by operational and financial reasons. In January 2010, Dr Chan launched a consultation on 'The future of financing for WHO', focusing on how to better align the priorities agreed by WHO's governing bodies with the monies available to finance them and, secondly, how to ensure greater predictability and stability of financing to promote more realistic planning and effective management (*The future of financing for WHO*, January 2010).

These operational challenges need to be addressed urgently; however, it was apparent, at this first consultation, that they cannot be addressed in isolation and that the occasion should also be used to make more profound reforms to WHO and make the organisation fit for the challenges of the 21st century.

Article 2 (a) of the WHO Constitution defines the first function of WHO *"to act as the directing and co-ordinating authority on international health work"*. While directing and coordinating might have had a different meaning over 60 years ago, with just a few international health actors, today it has become a real challenge. Top-down action, imposing a view on sovereign states and other actors, is no longer acceptable. Rather, WHO has to provide the platform for global health coordination and ensure a mechanism whereby all actors commit to a common purpose. It also has to provide the authoritative evidence base, norms and standards to direct international health work. WHO has to be at the heart of the global health landscape – and not above it. Directing cannot be interpreted as commanding, but rather as showing the way and providing the intellectual leadership to move the global health agenda forward.

WHO cannot do everything that is required to move global health forward and is neither best placed nor equipped for every task. WHO's total budget compared with overall international financing of development assistance for health fell from 23% in 1990 to 11.4% in 2007.[2]

2 Personal calculation based on data from the Institute for Health Metrics and Evaluation IHME DAH Database. Available at www.healthmetricsandevaluation.org/data. Accessed on 3 May 2011.

This makes proper priority-setting paramount. There are, however, a number of significant challenges with regard to priority-setting of WHO's work. WHO faces demands from many quarters, with many legitimate needs put forward by a range of actors. Funders pay for specific projects or programmes, a dominant feature that turns WHO into an organisation that is largely driven by donor funds. The Executive Board and the World Health Assembly find it difficult to reject a proposed resolution simply on the grounds that it does not fit in with the organisation's priorities. Member states and other donors tend to defend their pet projects and topics. WHO staff lobby donors and government officials in an effort to defend the programme or project they are working for. Member states tend to be inconsistent when some of their representatives ask for higher priority, while others demand that a particular issue not be abandoned. Member states have a tendency to defend their nationals who work for WHO, even if they underperform or when their skills no longer match WHO's needs.

Priority-setting is required, both for the work of WHO's governing bodies and for the Secretariat. Discussions on prioritisation lack a proper framework. WHO is working on different topics in global health and is fulfilling specific functions related to these topics. There is often a certain degree of confusion when it comes to discussing priority global health topics to be addressed by WHO and the priority functions of WHO. The fact that a topic is important does not mean that WHO should fulfil all related functions, nor does the importance of a function automatically mean that WHO should fulfil this function for all topics. Priority-setting discussions in a matrix approach will assist member states to consult with other global health stakeholders and, ultimately, to agree which combinations of functions and topics are priorities, and which ones are not priorities or should be left to other actors. The table below proposes such a matrix for illustrative purposes, based on an understanding of future priorities for WHO.

Table 1
Rating of priorities: global health topics and WHO's functions

	WHO's roles and functions								
Rating of priorities 4: Exclusive role 3: Lead actor 2: Major actor 1: Minor contributor 0: No significant role **Global health topics**	Negotiated global rules	Technical norms and standards	Convening role/global platform for coordination and coherence	Statistical data, global oversight	National technical advice	Advocacy for health and communication	Coordination at national level	Operative implementation programme	Financing
Health security	4	4	3	3	3	3	3	1	0
Disease elimination/eradication	4	4	3	3	3	3	2	1	1
Health system strengthening	4	3	3	3	3	2	1	0	0
Disease-specific work	4	4	3	3	3	2	1	0	0
Emergency relief	3	3	2	2	2	2	3	1	0
Health development cooperation	3	3	3	2	2	2	2	0	0
Health technologies	3	3	3	2	2	2	1	0	0
Health research	2	3	3	2	2	1	1	0	0
Health determinants	2	2	2	2	1	3	0	0	0

Note: This rating of priorities is based on a personal interpretation of what should be future priorities for WHO.

This is just one delimitation of WHO topics and functions. WHO used a different model in the *Eleventh General Programme of Work, 2006–2015* (2006), but did not distinguish between topics and functions. There are other ways of organising global health functions and other possible views on how to rate the priorities of WHO. This table is meant to illustrate where WHO should set its priorities and is not intended to be an operational tool for the actual priority-setting process within the organisation. Such a matrix could be used to set priorities, but it would have to be structured by WHO itself in consultation with its member

states and other stakeholders. It should also match, more closely, the defined core functions in order to obtain a practical tool to adapt the budget according to priorities. Furthermore, the reality is more complex in an organisation of this size with such a broad mandate. It would, however, be helpful to use a tool of this kind to progress in setting strategic priorities. It would be up to WHO member states, in consultation with other stakeholders, to agree on an implicit or explicit rating of priorities and find a way of implementing priorities in a reformed WHO. Another issue is the interaction and division of labour between WHO headquarters, the six regional offices and the 147 country offices (*WHO – its people and offices*, 2011). Many of these functions and topics are already set constitutionally, mainly in Article 2 (on functions) and Article 21 (on regulations). What is meant by these proposed topics and functions and how they are grounded in the WHO Constitution is described in the annex of this paper, 'Topics and functions'.

WHY USE A FUNCTION–TOPIC MATRIX FOR PRIORITY-SETTING?

Priorities for an organisation with such a broad universal mandate like WHO cannot be addressed in just one dimension. The importance of a global health topic or function alone can no longer mean that WHO should work on all its aspects. It must be the combination of a function with a topic that defines the priorities. Priority-setting through such a matrix draws on the following lessons:

- The easy part of priority-setting is to agree what should be a priority. But agreeing on what should *not* be a priority is rather more difficult. Once priorities have been set, it is necessary to adhere to agreed priorities over time.
- The challenge for the forthcoming WHO reform will be to decrease its work in the lower right-hand side of the matrix and increase it in the upper left-hand side.
- A matrix approach to priority-setting allows for discussions on what should be done by WHO and identifying where other global health actors are better placed to perform a task.
- Finally, concrete topic–function combinations clearly indicate the extent to which WHO should be active in them. Take the example of coordination at national level in emergency relief. This combination reflects WHO's lead of the global health cluster.[3] If WHO is to maintain this lead, then it needs sufficient resources in order to fulfil this task. Another such example is the combination of health technology and operational implementation programmes. Here, WHO should not be providing standard equipment not directly related to emergencies or health security.

Criteria drawn from the mandate conferred by WHO's Constitution are complemented by other criteria, such as the areas with greatest added value and comparative advantage or issues where WHO can tip the balance and have a major impact with limited resources. The balance between WHO's global normative role, its role in development cooperation in the 50 poorest countries and its advisory role to all countries (whether low- or high-income countries, or indeed in middle-income countries where income redistribution has yet to occur at domestic level) needs to be defined with greater clarity.

Ultimately, concrete priority-setting has to be undertaken by the governing bodies and the director-general in day-to-day business and in the medium term.

Priority-setting alone will neither be possible nor sufficient to enable WHO to face its challenges. An organisation, where less than 20% of its budget comes from assessed contributions from member states (*The future of financing for WHO*, January 2010) and where the majority of the voluntary contribution making up the rest of the budget is specifically allocated, cannot set and implement priorities in an adequate manner. Setting priorities and abandoning tasks at least

3 See also WHO Global Health Cluster. Available at www.who.int/hac/global_health_cluster/about/en/index.html. Accessed on 3 May 2011.

partially fulfilled by WHO also requires a stronger dialogue with other global health stakeholders. Last but not least, priority-setting requires internal managerial changes. Addressing reform under these headings would appear to make sense:

- priority-setting
- stakeholder involvement
- financial measures
- organisational/structural measures

As described earlier, not all possible reform steps can be taken at once. There is an immediate need for certain reforms to be addressed in the next one to two years. Secondly, some reform steps are possible over three to six years. Finally, major reform would probably take more than six years to decide, negotiate and implement. This is also in line with Fidler's (2010) convincing argument that "prospects for new, overarching reforms to global health architecture are negligible".

The following table summarises possible reforms of WHO proposed by different authors and ranks them into the short, medium and long term. Proposals in bold are those made by the WHO director-general for the discussions at the January 2011 meeting of the Executive Board (*The future of financing for WHO*, 2011). The current reform should focus on those issues that can be achieved in the short term and should not overload the agenda with longer-term reform issues.

Table 2
Possible reform proposals for WHO

	Priority-setting	Stakeholder involvement	Financial measures	Organisational/ structural measures
Short term/ immediate	**§ Define core activities** **§ Downsize some programmes** § Strengthen normative work § Prioritise the work of governing bodies	**§ Global Health Forum/Council** § Strengthening H8?	**§ Increase core voluntary contributions** § Other financial contributions (innovative financing, private donations)?	**§ Fewer, but more senior staff** with technical and negotiation skills § Improve transparency, performance and accountability
Medium term (Changes in rules of procedures, but no constitutional changes necessary)	§ True burden-sharing with other global health actors?	§ Charter (soft law) on global health § Committee C?	§ Increase assessed contributions Sound financial basis for normative functions	§ Clear distinction of roles between headquarters and regional offices
Long term (Some measures would require changes to the Constitution)		§ Framework Convention on Global Health? § Consolidate the number of global health actors	§ Global taxes?	§ Re-visit regional structure of WHO?

Note: Items in bold were proposed by the WHO director-general to the Executive Board in January 2011.

It is worth making a few comments, at this point, for each of the four categories: priority-setting, stakeholder involvement, financial measures, and organisational/structural measures.

Priority-setting

Priority-setting of the work of WHO as outlined above would clearly argue in favour of a strengthening of WHO's normative functions (illustrated in the upper left-hand corner of Table 1, 'Rating of priorities: global health topics and WHO's functions'.) This also requires an adequate budgetary allocation to this function. In recent years, several core normative processes, such as the negotiation of the International Health Regulations (2005) or the Intergovernmental

Working Group on Public Health, Innovation and Intellectual Property could only be financed through last-minute voluntary contributions instead of through the organisation's core budget. This is highly problematic. Just imagine a situation where a national parliament would have to raise funds from donations in order to hold a session of a subsidiary committee.

Priority-setting is not just required for the WHO Secretariat. The governing bodies should, on the one hand, decide – based on a proposal of the director-general – on the priorities of the Secretariat's work and, on the other, set priorities for their own work. Over the last 10 years the WHA, during annual sessions lasting 5 to 8 working days, passed a meeting average of more than 25 resolutions.[4] The majority of these resolutions urge member states to take action, and request the director-general to perform work. While member states carefully monitor the work of the director-general to confirm that what they requested regarding their pet topic has been delivered, their own commitments are often simply forgotten. Article 62 of the WHO Constitution reads as follows: *"Each Member shall report annually on the action taken with respect to recommendations made to it by the Organization and with respect to conventions, agreements and regulations."* Such reporting was abandoned over time, being considered too cumbersome as member states did not really report but, instead, presented themselves in the best possible light. Member states are therefore relatively relaxed about taking on commitments, since they will not be monitored.

Is proper priority-setting possible with so many distinct topic-specific resolutions? Could resolutions be better structured and focused? One option could be to replace the current single-issue resolutions with a limited number of 'omnibus' resolutions on topics such as health systems, communicable diseases, non-communicable diseases, health technologies and administrative matters that could reappear on the agenda every one to three years. In addition, a lean, online, transparent and effective reporting system on member states' implementation of WHO resolutions could be introduced. While WHO's Constitution does not need to be changed for the forthcoming necessary reforms, a revision of the rules or procedures of the governing bodies will probably be necessary.

In the medium term, proper priority-setting cannot be undertaken by WHO alone. Since WHO will have to abandon some tasks, there will be a need to share the burden with other actors. This can be done spontaneously, but other aspects will require preliminary negotiations with these actors followed by an endorsement by the World Health Assembly and the actors' governing bodies.

Stakeholder involvement

In an earlier article, we argued in favour of greater stakeholder involvement in the WHA by introducing a 'Committee C' (Silberschmidt, Matheson and Kickbusch, 2008; Kickbusch, Hein and Silberschmidt, 2010). While this would be feasible without changing the Constitution, there seems to be a consensus among member states that this is unlikely in the short term, partly because of concerns about rendering the already complex WHA unmanageable, and partly because of concerns about countries' sovereignty in their decision-making in WHO, which is a specialised agency of the UN.

WHO Director-General Margaret Chan has proposed introducing a mechanism to consult other stakeholders in a much more systematic way before each WHA. This has provisionally been referred to as a Global Health Forum. Many of the details of such a consultation mechanism have yet to be decided. How should this be composed? Should it be a broad and inclusive forum with many participants, and run the risk of not having any concrete outcomes, or should it instead be a narrow kind of council with stakeholders obliged to organise themselves in constituencies in order to be represented? Should it report to the WHA or to the EB? How many member states should be part of this structure? What should be the agenda and who should set

4 The resolutions are available at http://apps.who.int/gb/or/. Accessed on 3 May 2011.

it? In any case, such a structure has to play a clear role when it comes to shaping decisions, but leave the formal decision-making to member states in the World Health Assembly. Probably the best way forward would be a rather narrow council that would allow concrete discussions between a representative number of member states and stakeholders organised in constituencies.

Such a forum or council could hold its first session as early as late 2011 or early 2012. Whether or not, after a few years of experience, one comes back to the idea of integrating it into the WHA itself (or, perhaps, the EB) in a structure such as a Committee C remains to be seen.

One of the first tasks of a new Global Health Forum or World Health Council should be the elaboration of a draft soft law instrument on coordinating global health action in the field of development cooperation for health, which could be called a Global Health Charter. Whether or not this should later evolve into a binding agreement, such as a Framework Convention on Global Health (Gostin, 2007), remains be seen.

An existing coordination mechanism amongst the major global health actors is the so-called Health 8 or H8.[5] This is a purely informal consultation mechanism that brings together the heads of the following eight organisations: WHO, UNAIDS, the World Bank, GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization), UNICEF, The Global Fund to Fight AIDS, Tuberculosis and Malaria, UNFPA, and the Bill & Melinda Gates Foundation. Should the H8 be strengthened and given a mandate by governments, or does it best fulfil its role by retaining its purely informal nature?

A significant consolidation of global health actors cannot realistically be achieved in the short or medium term. Such issues should, therefore, not be mixed up with the current reforms.

5 See also *Health 8 group meet to discuss maximizing health outcomes with available resources and getting "more health for the money"*. Available at *www.unaids.org/en/resources/presscentre/featurestories/2011/february/20110223bh8/*. Accessed on 3 May 2011.

Financial measures

As described by the director-general in her report to the Executive Board in 2011 (*The future of financing for WHO*, December 2010), WHO urgently needs a higher proportion of flexible funding. The necessary increase in the fees paid by member states, the so-called assessed contribution, will take some time to have an effect. Member states should therefore also un-earmark an increasing proportion of their voluntary contributions and WHO should be allowed to look for other, innovative sources of funding.

Organisational/structural measures

The necessary organisational reforms were clearly outlined by Dr Chan in her concluding remarks on the reform debate at the Executive Board meeting in January 2011 (*The future of financing for WHO*, 2011). They have to include a new results-based planning framework, a revised human resource strategy "facilitating recruitment of high quality, competent, experienced staff to provide high quality service to Member States", including revisions to the staff regulations and "organizational design, which include: a clear division of labour for the three levels of WHO and a plan for aligning the staffing and resourcing of the offices with these functions".

Such a reform can only be successful if member states give full their support, including support to measures that may not please their own nationals who work for WHO. WHO can only fulfil its function if it can count the world's best experts amongst its staff and if the staffing profile can be expanded to include – as well as health professionals – economic, legal, diplomatic, policy and social science skills.

WHO is also increasingly being called upon to improve transparency, performance and accountability (Sridhar and Gostin, 2011). In a recent multilateral aid review, the UK government rated WHO as weak on these criteria (Department for International Development, 2011). A better performance and a better perception of these management functions will also be crucial in motivating member states and other donors to trust WHO and give more non-earmarked funding to the organisation.

There are other longer-term institutional challenges; the regional structure of WHO would politically be too sensitive an issue to touch and would require a change in the Constitution.

CONCLUSION

In my view, the time has come to make WHO fit for the challenging tasks it faces in the 21st century. While reforms have been an integral part of the history of the UN system, a window of opportunity now seems to be presenting itself for a meaningful reform of WHO. Priority-setting means abandoning tasks and focusing on what an organisation is uniquely or best positioned to achieve. For WHO, this means moving activities and resources to the more normative upper left-hand corner of the topic–function matrix (Table 1 on the rating of priorities for WHO's roles and functions on different global health challenges). I propose that the lower right-hand corner be left to other actors.

Priority-setting, however, is not possible without addressing the other major challenges of reform that aim to better involve other stakeholders, create a more stable financial basis and implement internal managerial reforms.

WHO is central to global health governance: let's reform and strengthen WHO now!

Annex 1: TOPICS AND FUNCTIONS

TOPICS

Health security

International interdependence in health was recognised in the very first efforts of international cooperation on health topics in 1851, when European states gathered for the first International Sanitary Conference to secure each other's cooperation on cholera, plague and yellow fever (Howard-Jones, 1975).

One hundred years later, the WHO Constitution came into being and conferred on WHO a treaty-making authority. According to Article 21: *"The Health Assembly shall have authority to adopt regulations concerning: (a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease."* The International Health Regulations (2005) together with the Framework Convention on Tobacco Control (FCTC) are the first legally binding instruments negotiated under the auspices of WHO. Their purpose, as defined in the International Health Regulations (2005) Article 2, is to *"prevent, protect against, control and provide a public health response to the international spread of disease"*.

Disease elimination/eradication

The elimination and eradication of diseases (Dowdle, 1998) requires exceptional international cooperation. The WHO Constitution makes special reference to this function in Article 2 (g) *"to stimulate and advance work to eradicate epidemic, endemic and other diseases"*. This is the classic example of the creation of a global public good (Kaul and Faust, 2001); it cannot work if it is not universal and everybody ultimately profits from it. This topic evidently overlaps with health security and with disease-specific work. Nevertheless, as a separate category, the provision of a global public good underpins

WHO's direct operative involvement, such as in the eradication of smallpox in the 1970s or current polio eradication efforts.

Health system strengthening

The key components of a health system are: leadership and governance, health information systems, health financing, human resources for health, essential medical products and technologies, and service delivery.[6] Strengthening health systems was at the forefront of WHO's work with the Alma-Ata declaration on primary healthcare in 1978, but subsequently lost momentum. The renewed recognition of the importance of health systems, with all their components, is illustrated in the 2010 edition of *The World Health Report – Health systems financing: The path to universal coverage*. The importance of health systems was already recognised by several functions described in the Constitution:

- Article 2 (c) – *"to assist Governments, upon request, in strengthening health services"*
- Article 2 (o) – *"to promote improved standards of teaching and training in the health, medical and related professions"*
- Article 2 (p) – *"to study and report on, in co-operation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security"*

Disease-specific work

The ongoing debate on the horizontal, vertical or diagonal approaches to health (Ooms et al, 2008) is not relevant here. The fact is that as well as looking at the components of the health system, the Constitution of WHO also speaks of approaches to specific diseases, both infectious and non-communicable:

- Article 2 (g) – *"to stimulate and advance work to eradicate epidemic, endemic and other diseases"*
- Article 2 (h) – *"to promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries"*
- Article 2 (m) – *"to foster activities in the field of mental health, especially those affecting the harmony of human relations"*
- Article 2 (s) – *"to establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices"*

Emergency relief

The Constitution gives WHO a clear mandate to act in emergency situations:

- Article 2 (d) – *"to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments"*
- Article 2 (e) – *"to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories"*

In view of the important resources associated with the more operative functions of WHO in emergency situations, careful consideration should be given to define the work that is best carried out by WHO itself or where other players would be better placed to do so.

Health development cooperation

This topic partly overlaps with health system strengthening and disease-specific work, but focuses on implementation in low-income countries. Here, the challenge is to prioritise those functions that should be performed directly by WHO. There is certainly a constitutional basis starting with Article 1: "*The objective of the World Health Organization… shall be the attainment by all peoples of the highest possible level of health".* This continues in Article 2 (c) *"to assist Governments, upon request, in strengthening health services"* and in Article 2 (l) *"to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment"*. While WHO has a role to play in development cooperation and, in particular, in the implementation of the Millennium Development Goals, WHO is not a development agency for health.

6 See also 'Key components of a well functioning health system'. Available at www.who.int/healthsystems/EN_HSSkeycomponents.pdf. Accessed on 3 May 2011.

Health technologies

The importance of health technologies, including medical products (medicines, vaccines and diagnostics) and medical devices continues to grow with technological and economic development. But, as the Constitution has made clear, WHO has to play a clear role concerning health technologies:

- Article 2 (t) – *"to standardize diagnostic procedures as necessary"*
- Article 2 (u) – "*to develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products"*
- Article 21 – *"The Health Assembly shall have authority to adopt regulations concerning:*
  - (c) – *standards with respect to diagnostic procedures for international use;*
  - (d) – *standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;*
  - (e) – *advertising and labelling of biological, pharmaceutical and similar products moving in international commerce."*

Health technologies are one aspect of health systems and could be included in this topic. I propose a separate category, since questions linked to health technology are often controversial and WHO has a clear role to play in this area.

Health research

Health research was clearly a central function in the early days of WHO in accordance with Article 2 (n) *"to promote and conduct research in the field of health".* The specific role and added value of WHO needs to be identified, in view of the increased resources and number of actors in health research.

Health determinants

In recent years, the evidence base of the environmental, social and political determinants of health has increased. Some of them were already addressed in the Constitution: Article 2 (i) – *"to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene."*

FUNCTIONS

Negotiated global rules

One of the main functions of WHO is the negotiation of global rules governing health. This is clearly spelt out in Article 2 (k): "*to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective"*. These are elaborated further in Article 19, which states that *"The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization"*, and Article 21, according to which *"The Health Assembly shall have authority to adopt regulations concerning:*

- (a) – *sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;*
- (b) – *nomenclatures with respect to diseases, causes of death and public health practices;*
- (c) – *standards with respect to diagnostic procedures for international use;*
- (d) – *standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;*
- (e) – *advertising and labelling of biological, pharmaceutical and similar products moving in international commerce."*

Articles 19 and 21 refer to binding international law, the so-called hard law, while Article 23, which states that *"The Health Assembly shall have authority to make recommendations to Members with respect to any matter within the competence of the Organization"*, gives the WHA the authority to negotiate and adopt non-binding

international law such as resolutions, charters, global strategies and action plans – the so-called soft law (Silberschmidt, 2010).

Technical norms and standards

Closely related to global rules adopted and negotiated by governments, WHO has amply used its mandate to elaborate technical norms and standards:

- Article 2 (s) – *"to establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices;*
- Article 2 (t) – *to standardize diagnostic procedures as necessary;*
- Article 2 (u) – *to develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products"*

In addition to this technical normative function, WHO exercises an overarching policy function derived from the directing role described in Article 2 (a). This clearly asks for WHO leadership in proposing and shaping global health policies.

Convening role/global platform for coordination and coherence

The primary function of WHO is described in Article 2 (a) *"to act as the directing and co-ordinating authority on international health work"*. Furthermore, other constitutional functions confer on WHO a unique position of competence in all aspects of global health:

- Article 2 (b) – *"to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate"*
- Article 2 (j) – *"to promote co-operation among scientific and professional groups which contribute to the advancement of health"*
- Article 2 (v) – *generally to take all necessary action to attain the objective of the Organization"*

As described in Article 2 (b), WHO has a dual coordination function on health within the UN system and with other actors.

Statistical data, global oversight

WHO has a technical function to gather universal statistical data and to provide a global oversight of health matters, as mentioned in Article 2 (f), *"to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services"* and in Article 2 (q) *"to provide information, counsel and assistance in the field of health"*.

National technical advice

WHO is a highly decentralised organisation with an extensive network of country offices providing technical advice at national level, and is based on the following Articles:

- Article 2 (d) – *"to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments"*
- Article 2 (q) – *"to provide information, counsel and assistance in the field of health"*
- Article 33 – "*The Director-General or his representative may establish a procedure by agreement with Members, permitting him, for the purpose of discharging his duties, to have direct access to their various departments, especially to their health administrations and to national health organizations, governmental or non-governmental...*"

Given the impact of WHO's country presence and the resources used, the exact nature and priorities of WHO's work at country level will have to be analysed thoroughly during the forthcoming reform process.

Advocacy for health and communication

Article 2 (i) seeks *"to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene"*. This recognises that health determinants are not influenced by the health sector alone. WHO has to cooperate closely with other sectors. Closely linked to this role of advocacy for health is the communication function, as described in

Article 2 (q) *"to provide information, counsel and assistance in the field of health"* and Article 2 (r) *"to assist in developing an informed public opinion among all peoples on matters of health."*

Coordination at national level

The Constitution does not speak of a coordination function of WHO at the country level, since the intensity of international exchanges and the number of international actors at that time were much lower. Nevertheless, a proposal to subsume a coordination function distinct from the national technical advisory function would enable a more precise analysis of this aspect of WHO's work.

Operative implementation programme

The Constitution did not establish WHO as a primarily operational organisation providing health services on its own through implementation programmes such as those of other UN organisations, development agencies or non-governmental organisations (NGOs). This is one of the functions in global health that is better performed by other actors and where WHO should reduce its activities. Any references in the Constitution that could be interpreted as providing a mandate for operational programmes are always described in a subsidiary role to governments or the UN:

- Article 2 (c) – *"to assist Governments, upon request, in strengthening health services;*
- Article 2 (d) – *to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments;*
- Article 2 (e) – *to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories".*

Financing

It is a common misconception that WHO should finance health-related activity. WHO has no mandate and is not set up as financing agency. While WHO is currently seen – and is sometimes used – as a financing agency, this should not be the case in the future.

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