The Global Forum

The WHO and the COVID-19 Pandemic

Less Reform, More Innovation

Kelley Lee

Faculty of Health Sciences, Simon Fraser University, Burnaby,
British Columbia, Canada

Julianne Piper

Faculty of Health Sciences, Simon Fraser University, Burnaby,
British Columbia, Canada

1 Introduction

Public displays of gratitude around the world, championing frontline health workers as heroes during the COVID-19 pandemic, have contrasted sharply with the criticisms directed toward the World Health Organization (WHO). As the “directing and coordinating body for international health work,” the UN specialized agency has arguably been at the front line of the front line, gathering essential epidemic intelligence, convening scientific research collaborations, and compiling technical guidelines on diagnostics, clinical care, prevention, and mitigation strategies. While playing this unique role, including regular media briefings throughout the pandemic, WHO officials have fielded questions about its performance against the backdrop of relentless increases in coronavirus infections and deaths worldwide. The withdrawal of funding and membership by the US government,¹ and resolution adopted by Member

¹ Trump 2020.

States at the 73rd World Health Assembly “to initiate ... [an] impartial, independent and comprehensive evaluation ... [of] the WHO-coordinated international health response to COVID-19,”² reflects a concerning loss of confidence in the WHO at a time when the world needs it the most. So, how did we get here and what is the way forward?

To answer these questions, it is important to distinguish between short-term political points scoring by the Donald Trump administration to explain a floundering national pandemic response during an election year, and long-standing challenges at the heart of global health governance. The former is inflicting collateral damage on the latter, a more important debate about the disconnect between existing global institutions and collective action in a changing world. The COVID-19 pandemic provides an opportunity to address this disconnect, either through new reforms or a deeper reimagining of global governance.

2 The WHO in the Time of Pandemics

The “control of the international spread of disease,” while avoiding unnecessary interference with “traffic and trade,” is a central and historic function of the WHO.³ This responsibility, and the authority to fulfill this function, is set out in the International Health Regulations (IHR), revised in 2005, a binding international agreement endorsed by 194 Member States (plus two non-member states). Under the IHR (2005), national governments are also responsible for ensuring core public health capacities to detect and respond to disease events, and to report such events to the WHO within twenty-four hours. Hundreds of disease events are reported to the WHO annually, which are shared with Member States. The director-general, with the support of an Emergency Committee if needed, determines whether any event constitutes a Public Health Emergency of International Concern (PHEIC). The declaration of a PHEIC enables the WHO to provide temporary recommendations that Member States commit to follow, typically concerning best public health practices and advisories regarding international travel and trade restrictions. The WHO can also exercise its unique convening powers, initiating and coordinating shared efforts to advance research on diagnostics, vaccines, and antiviral treatments.

Since coming into effect, the IHR (2005) has been used to declare a PHEIC six times, including the COVID-19 pandemic. In two cases, the WHO has been

² WHO 2020a.

³ WHO 2005.

criticized for how the IHR has been applied. For the H1N1 influenza pandemic (2009), the WHO was deemed to have overreacted when the illness proved less severe, causing unnecessary harms to national economies.⁴ For the Ebola virus outbreak (2014–2015) in West Africa, the WHO was found to have acted too slowly, in declaring a PHEIC, mobilizing international resources, and providing technical expertise. This resulted in thousands of unnecessary deaths, economic hardship for local communities, and broader interference to international trade and travel.⁵

The heat felt by the WHO during the COVID-19 pandemic is somewhat reminiscent of these previous criticisms—Did the WHO act swiftly enough in declaring a PHEIC; should more pressure have been put on China to report events openly; and could the unprecedented disruptions to international traffic and trade have been prevented?⁶ For the most part, the WHO has performed as the IHR (2005) is currently designed. Epidemic intelligence has been gathered, alerts have been made, and a steady flow of recommendations have been produced based on emerging scientific evidence about a novel pathogen. The WHO has also operated within the existing boundaries of the authority and resources provided by Member States. The frustrations with the WHO for not calling out governments for their noncompliance with the IHR seem misplaced given a governance structure that upholds the primacy of Member States, a budget that makes the organization a hostage to fortune, and a constitution that bestows no enforcement powers.

In this context, the WHO embodies the disconnect between the shared risks of a globally interconnected world, and existing institutional arrangements to achieve collective action. Some critics view the WHO's limitations in global outbreak response as signs of its inevitable demise.⁷ With its mandate, structure, governance, and funding reflecting a mid-century modern vision of world order, to what extent is the WHO suitably equipped to operate in an increasingly globalized world? How, then, might we move forward?

3 Four Approaches to Reform of the WHO

Since the 1990s, the WHO has been the subject of many reform debates, ranging from broad aspects of the organization's mandate, structure, and func-

4 Council of Europe 2010.

5 Moon et al. 2015.

6 Lee et al. 2020.

7 Fidler 2020.

tions, to the effectiveness of specific programs. Almost every incoming director-general has initiated their own reform program in response to internal needs or external concerns. In addition, many externally led reviews have been initiated focused on the WHO's budget,⁸ country offices,⁹ or performance during specific disease events. Yet other reviews have analyzed the WHO within a changing global governance landscape.¹⁰ The announcement of an Independent Panel for Pandemic Preparedness and Response in July 2020, "to evaluate the world's response to the COVID-19 pandemic,"¹¹ should thus be understood in this context. The desire and recognized need for an effective global health organization is therefore hardly new. Amid a global pandemic that has shaken the world, and stopped the world economy in its tracks, there is a rare opportunity to move from a long-standing impasse to real change. The key challenge now is to find a way of moving beyond the months of mudslinging and divisive political posturing toward a shared vision of collective action.

One way of sifting through the abundance of past ideas put forth on WHO reform is to use the analogy of an aging computer. What one does with such a computer depends on available resources, current needs, and available technology. Using this analogy, four basic approaches have been put forth on WHO reform.

3.1 *The WHO past Its Use by Date: Time for Retirement?*

The founding mandate, organizational structure, and governing principles of the WHO, all of which remain largely intact today, embody an uneasy post-war compromise between two worldviews. While liberal internationalists envisioned a UN specialized agency for health as an institutional pillar for achieving peace and prosperity, the authority granted to the WHO to play this role remained curtailed as a Member State organization. This disconnect between aspiration and authority is amplified by the inclusive definition of *health* in the WHO's constitution as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."¹² Tasked with the objective of "the attainment by all peoples of the highest possible level of health,"¹³ the WHO from birth has been caught between pursuing this

8 Vaughan et al. 1996.

9 Lucas et al. 1997.

10 Lee 1998.

11 WHO 2020b.

12 WHO 1946, Preamble.

13 WHO 1946, Art. 1.

visionary ‘health for all’ future¹⁴ and delivering on a pragmatic disease-focused present. This embedded tension became evident in perennial arguments about the WHO’s work program. As Member States grew, from 55 in 1948 to 194 in 2020, the needs of low- and middle-income countries became an increasingly important focus of the WHO’s efforts. Disagreements arose about how to best support health development—through primarily disease-focused initiatives or by addressing the broader social determinants of health. The greatest sceptic of the latter, the United States, more often than not got its way as the most politically and economically influential among the Member States. When it did not, such as when the WHO advocated for access to essential medicines, standards to curtail baby food companies, and universal health coverage, the US government led a curtailment of the WHO’s budget in the 1980s, which remains intact today. By freezing Member States’ assessed contributions in real and then actual terms, major donors circumvented the plenary power of the World Health Assembly and turned the WHO’s work program into a buffet. In 2020, donor controlled extrabudgetary (voluntary) contributions represented around 75 percent of the WHO’s total budget.

Caught between a rock and a hard place, some advocates of WHO reform see no alternative but to go back to the drawing board. Like an old clapped out computer that cannot be repaired or renovated, the WHO might simply be considered an institutional relic created for a different time. Whether it should be replaced, and if so with what, elicits widely differing opinions. At the two extremes are: isolationists who, by their nature, will not rush to build a new organization; and globalists who wish to see WHO 2.0 rise from the ashes. The latter will be no easy feat. Indeed, the challenge of institutional building may be even more daunting than after World War II. An emerging multipolar world order may mean greater diversity of perspectives. The relative roles of state and nonstate actors must be grappled, while taking account of the diversity and stark inequities among their ranks. And an agreed funding formula that is deemed fair and enables a new organization to fulfill its assigned role will need to be a priority discussion.

3.2 *Refurbishing the WHO with Add-Ons*

A second approach to WHO reform is to enhance the old computer with peripherals that add to its capacities in ways that meet changing needs. In some ways, this has been the de facto evolution of the WHO, as an institution defined by an expansive mandate without commensurate increases in resources or

14 Pandey 2018.

authority. In 1948 when WHO was established, its Secretariat consisted of the Office of the Director-General and three departments, cumulatively comprising four divisions, three sections, and two offices.¹⁵ By 1981, the number of organizational subdivisions had more than tripled. In addition to the director-general's office, there were five assistant directors-general overseeing portfolios encompassing fifteen divisions, six programmes and three offices.¹⁶

The organizational expansion of the WHO over the second half of the twentieth century can be attributed to several factors amid a dynamic institutional landscape. To some extent, the add-ons of divisions, departments, and programs reflects an internal response to conflicting external views of what role the WHO should play, and relatedly which health issues it should prioritize. The organizational design comprising an Executive Board of thirty-four technical experts lent itself well to the WHO's providing of technical and scientific expertise on an initially narrow conception of international health cooperation, focused on disease control and eradication. However, with a constitution setting out a broad definition of health and twenty-six functions,¹⁷ competing expectations have long persisted regarding the appropriate scope of the WHO's operations, leadership, and technical and scientific expertise.¹⁸ These tensions also reflect differences between a biomedical perspective of health and focus on the clinical care of individuals, and a social medicine approach focused on addressing population-level factors within broader society. The latter includes the Health for All agenda since the late 1970s.

By the 1980s, the WHO began to resemble a tangled garden as a result of efforts to progress the diverse health needs of Member States across three tiers of operation (headquarters, regions, country offices). Concerns about the WHO's ponderous bureaucratic structure became a concern at a time when a rapidly changing external environment called for agility and nimbleness. Rather than adding further peripherals to the WHO's basic framework, major donors funded new initiatives outside of the organization. These include the Joint United Nations Programme on HIV/AIDS (UNAIDS); Global Fund to Fight AIDS, Tuberculosis and Malaria; and Global Alliance on Vaccines and Immunization (GAVI). Thus, the reform model of adding more peripherals to the WHO had run its course by the 1990s. Without major changes to structure and financing, more add-ons would mean further overloading the WHO and spreading its limited capacities ever more thinly.

¹⁵ WHO 1958.

¹⁶ WHO 1982.

¹⁷ WHO 1946, Art. 2.

¹⁸ Wenham 2017.

3.3 *The WHO as Network Coordinator*

A third approach to reform situates the WHO as part of a network of organizations. The current institutional landscape for global health cooperation evolved in a piecemeal fashion, driven by donor preferences and perceived health priorities. Reflecting dissatisfaction with the WHO, donors deployed the boon in global health funding to new initiatives. Viewed as either unresponsive to donor priorities, or too riddled with sclerosis to change, the WHO was becoming marginalized as donors voted with their feet. The WHO became trapped in a perpetual cycle (which persists today) of not having sufficient resources to effectively achieve objectives, and donors viewing these unmet objectives as disincentives for increasing funding. This period of growing interest in global health also witnessed increased influence of private foundations (e.g., Bill and Melinda Gates Foundation) and private-public partnerships (e.g., Unitaid). By 2008, there were more than forty bilateral donors, twenty-six UN agencies, twenty global and regional funds, and ninety global health initiatives.¹⁹

Some have proposed a repositioning of the WHO as the coordinator of a global health network of actors. This would bring together the WHO's technical expertise and appropriate partners to address the growing need for multisectoral and multilevel action in global health cooperation. Within the realm of global outbreak response, Allyn L. Taylor and Roojin Habibi suggest that the "WHO has neither the legal and political authority nor the technical capacity to address economic, social, and health consequences of devastating global pandemics alone." Instead, they support "the establishment of a framework in which the WHO continues to serve the central role envisaged by parties to the IHR in using its scientific, medical and public health capabilities, as well as its normative role, to effectively assist states to prevent, detect, and respond to disease outbreaks."²⁰ The Access to COVID-19 Tools (ACT)-Accelerator is a potential model for such a network approach. Launched in April 2020 by the WHO director-general, the initiative brings together diverse actors—governments, global health initiatives, scientists, businesses, civil society, and philanthropies—to speed "the development and equitable distribution of the tests, treatments and vaccines the world needs to reduce mortality and severe disease, restoring full societal and economic activity globally in the near term, and facilitating high-level control of COVID-19 disease in the medium term."²¹ The vaccine arm of ACT-Accelerator, the COVAX Facility, led by the Coalition for

¹⁹ McColl 2008.

²⁰ Taylor and Habibi 2020.

²¹ WHO n.d.

Epidemic Preparedness Innovations (CEPI), GAVI, and the WHO, and supported by 156 economies,²² demonstrates the capacity of the WHO to rapidly mobilize networks around priority global health needs with key partners.

There remain two key challenges with this network reform model. The first is trust in and compliance with the WHO leadership. Historically, the WHO has been recognized as the technical leader for international health cooperation. This would need to be reestablished in the wake of the COVID-19 pandemic if the WHO's lead role is to have any meaning. The second is the laissez-faire evolution of existing actors, creating gaps and overlaps in function and mandate. Any effective network model of global health governance would need to rationalize the current configuration and strengthen priority functions.

3.4 *Innovation in Global Health Governance*

A fourth option is a more fundamental reimagining of global health governance for a post-COVID19 world. In the private sector, economic globalization has pushed large firms to innovate or die within a more dynamic world economy. This is evidenced by the decline in life expectancy of Fortune 500 companies from seventy-five to fifteen years since the 1960s.²³ While global institutions should not “go out of business” so readily, their need to remain “fit for purpose” is no less critical.²⁴ In this respect, the WHO embodies a postwar model of public administration designed to effectively carry out routine functions amid stability and predictability. Today, this model is arguably out of step in a world where adaptation to more rapid change, greater complexity, and closer interconnectedness is critical to institutional resilience.²⁵ The travails of reforming the WHO, in many ways, reflects this challenge, leading us to the “gridlock” that Thomas Hale and David Held define as “deadlock or dysfunctionality in existing organizations and the inability of countries to come to new agreements as issues arise.”²⁶ The failings of global health governance during the COVID-19 pandemic has been a consequence of this.

To get “beyond gridlock”, this fourth approach pushes us to shift from fixing the WHO, in part or whole, to applying innovation thinking to building global institutions.²⁷ Ann Florini and Sunil Sharma, for example, describe COVID-19 as “an overdue reckoning about our world’s ability to manage systemic haz-

22 GAVI 2020.

23 Denning 2011.

24 Kaldor 2016.

25 Smith and Lee 2017.

26 Hale and Held 2017, p. 19.

27 Lee 2016.

ards” due to “increasing fragility in our political, social, economic, and financial orders.”²⁸ In this sense, global governance is about building societies’ resilience across a full range of threats, including climate change, pandemic diseases, and economic crises. Global health security might thus be alternatively conceptualized as part of a complex adaptive system,^{29,30} “nimble or agile in the sense that they can adapt easily to changing circumstances, without losing their capacity to steer human-environment interactions effectively.”³¹ Such systems pose novel governance challenges because of higher connectivity, nonlinear dynamics, multidirectional patterns of change, and emergent properties.

In summary, while it may not feel like it, we are in the process of dodging a bullet with COVID-19. The findings of the Independent Panel for Pandemic Preparedness and Response will be an important document. However, to emerge from this pandemic with simply another pile of post-outbreak evaluations would be a worst-case scenario. With the passing of decades of gridlocked debate about WHO reform, the world has become increasingly vulnerable to shared global health risks. The WHO’s founding was prompted by the aspirations and health needs of the postwar period. In the twenty-first century, it is high time for a different conversation.

Bibliography

- Council of Europe. *Handling of the H1N1 Pandemic—More Transparency Is Needed*. Resolution 1749 (2010). Final version, Brussels (24 June 2010). <https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=17889&lang=en>.
- Denning, Steve. “Why Did IBM Survive?” *Forbes*, 10 July 2011. <http://www.forbes.com/sites/stevedenning/2011/07/10/why-did-ibm-survive/>.
- Fidler, David P. “The World Health Organization and Pandemic Politics: The good, the Bad and an Ugly Future for Global Health.” *Think Global Health*, 10 April 2020. <https://www.thinkglobalhealth.org/article/world-health-organization-and-pandemic-politics>.
- Florini, Ann, and Sunil Sharma. “Reckoning with Systemic Hazards.” *Finance and Development* 57 (2) (2020), 48–51. <https://www.imf.org/external/pubs/ft/fandd/2020/06/pdf/reckoning-with-systemic-hazards-florini.pdf>.
- GAVI (Global Alliance on Vaccines and Immunization). “Boost for Global Response

28 Florini and Sharma 2020, p. 49.

29 Lakoff 2017.

30 Hill 2011.

31 Young 2017, p. 5.

- to COVID-19 as Economies Worldwide Formally Sign up to COVAX Facility." Media release, Geneva, 21 September 2020. <https://www.gavi.org/news/media-room/boost-global-response-covid-19-economies-worldwide-formally-sign-covax-facility>.
- Hale, Thomas, and David Held. *Beyond Gridlock* (London: Polity Press, 2017).
- Hill, Peter S. "Understanding global health governance as a complex adaptive system." *Global Public Health* 6 (6) (2011), 593–605.
- Kaldor, Mary. "Our Global Institutions Are Not Fit for Purpose: It's Time for Reform." World Economic Forum, 8 July 2016. <https://www.weforum.org/agenda/2016/07/our-global-institutions-are-not-fit-for-purpose-it-s-time-for-reform/>.
- Lakoff, Andrew. *Unprepared: Global Health in a Time of Emergency*. (Oakland: University of California Press, 2017).
- Lee, Kelley. "Shaping the Future of Global Health Cooperation: Where Can We Go from Here?" *Lancet* 351 (9106) (1998), 899–902.
- Lee, Kelley. "Business as Usual: A Lack of Innovation in Global Health Governance." *International Journal of Health Policy and Management* 5 (11) (2016), 1–3.
- Lee, Kelley, Catherine Z. Worsnop, Karen A. Grépin, and Adam Kamradt-Scott. "Global Coordination on Cross-Border Travel and Trade Measures Crucial to COVID-19 Response." *Lancet* 395 (10237) (2020), 1593–1595.
- Lucas, Adetokunbo, Sigrun Mogedal, Gill Walt, Sissel Hodne Steen, Stein-Erik Kruse, Kelley Lee, and Laura Hawken. *Cooperation for Health Development, The World Health Organisation's Support to Programmes at Country Level* (London: Governments of Australia, Canada, Italy, Norway, Sweden, and UK, 1997).
- McColl, Karen. "Europe Told to Deliver More Aid for Health." *Lancet* 371 (9630) (2008), 2072–2073.
- Moon, Suerie, Devi Sridhar, Muhammad A. Pate, Ashish K. Jha, Chelsea Clinton, Sophie Delaunay, Valnora Edwin et al. "Will Ebola Change the Game? Ten Essential Reforms before the Next Pandemic: The Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola." *Lancet* 386 (10009) (2015), 2204–2221.
- Pandey, Kiran Raj. "From health for all to universal health coverage: Alma Ata is still relevant." *Globalization and Health* 14 (2018), Article 62.
- Smith, Richard, and Kelley Lee. "Global Health Governance: We Need Innovation Not Renovation." *BMJ Global Health* 2 (2017), e000275.
- Taylor, Allyn L., and Roojin Habibi. "The Collapse of Global Cooperation under the WHO International Health Regulations at the Outset of COVID-19: Sculpting the Future of Global Health Governance." *American Society of International Law—Insights* 24 (5) (2020). <https://www.asil.org/insights/volume/24/issue/15/collapse-global-cooperation-under-who-international-health-regulations>.
- Trump, Donald. "Letter to Dr. Tedros Adhanom Ghebreyesus." White House, Washington, DC, 18 May 2020.
- Vaughan, J. Patrick, Sigrun Mogedal, Stein-Erik Kruse, Kelley Lee, Gill Walt, and Koen

- de Wilde. "Financing the World Health Organization: Global Importance of Extra-budgetary Funds." *Health Policy* 35 (3) (1996), 229–245.
- Wenham, Clare. "What We Have Learnt about the World Health Organization from the Ebola Outbreak." *Philosophical Transactions of the Royal Society B* 372 (1721) (2017), 20160307. <http://dx.doi.org/10.1098/rstb.2016.0307>.
- WHO (World Health Organization). *Constitution of the World Health Organization*. 1946. https://www.who.int/governance/eb/who_constitution_en.pdf.
- WHO. *The First Ten Years of the World Health Organization*. Geneva, 1958. https://apps.who.int/iris/bitstream/handle/10665/37089/a38153_eng_LR_part1.pdf.
- WHO. *The Work of WHO, 1980–1981: Biennial Report of the Director-General to the World Health Assembly and to the United Nations*. 1982. <https://apps.who.int/iris/handle/10665/204369>.
- WHO. *International Health Regulations, Revised*. Geneva, 2005. <https://www.who.int/ihr/publications/9789241580496/en/>.
- WHO. *COVID-19 Response*. 73rd World Health Assembly, Agenda Item 3, 19 May 2020a. https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R1-en.pdf.
- WHO. "Independent Evaluation of Global COVID-19 Response announced." News release, 9 July 2020b. <https://www.who.int/news-room/detail/09-07-2020-independent-evaluation-of-global-covid-19-response-announced>.
- WHO. "The Access to COVID-19 Tools (ACT) Accelerator." Geneva, n.d. <https://www.who.int/initiatives/act-accelerator>.
- Young, Oran R. *Governing Complex Systems, Social Capital for the Anthropocene* (Cambridge: MIT Press, 2017).